Patient Information

Ilan Bazak, DPM a Professional Corporation

LAST NAME_____ FIRST NAME_____

AGE_____ SEX_____DATE OF BIRTH_____MARITAL STATUS S__M__W__D__

ADDRESS_____CITY_____ZIP_____

HOME PHONE_____SOCIAL SECURITY_____

EMPLOYED BY_____BUSINESS ADDRESS_____

OCCUPATION_____BUSINESS PHONE_____

REFERRED BY_____FAMILY PHYSICIAN_____

WHAT IS YOUR CHIEF FOOT PROBLEM_____

FORMER FOOT DOCTOR_____LAST VISIT_____

PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT_____
PERSON TO NOTIFY IN CASE OF AN EMERGENCY_____
RELATIONSHIP_____PHONE_____

HEALTH INSURANCE

NAME OF INSURANCE COMPANY_____MEDICARE #_____
CERTIFICATE#_____GROUP_____INSURED_____
POLICY#_____ DEDUCTIBLE_____IS DEDUCTIBLE MET THIS YEAR_____
DO YOU HAVE A SECONDARY INSURANCE_____

MEDICAL INFORMATION

WHAT PRESCRIPTION MEDICATION DO YOU CURRENTLY TAKE?_____
_____
ARE YOU ALLERGIC TO ANY MEDICATION SUCH AS PENICILLIN, ANESTHETICS OR PAIN MEDICATION IF SO WHICH ?_____
DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS: HEART DISEASE, DIABETES, HIGH BLOOD PRESSURE, ARTHRITIS, STOMACH ULCERS, LIVER OR KIDNEY PROBLEMS ?_____
_____
ARE YOU SUBJECT TO PROLONGED BLEEDING_____FEMALE PATIENTS ARE YOU PREGNANT?_

I herby authorize my permission to Dr. Ilan Bazak, DPM and his associates to administer treatment for my foot condition as may be deemed necessary in the diagnosis and treatment of my foot condition.
DATE_____SIGNATURE_____
If patient is a minor or incompetent Parent or Guardian's SIGNATURE_____
I Hereby attest that the information above is true and correct to the best of my knowledge. I understand and agree that I am ultimately responsible for the balance of my account for any and all professional services rendered. Should I for any reason be determined ineligible for insurance benefit , I or the person responsible for me, will pay the amount billed in full within 30 days of receiving notice.
DATE_____SIGNATURE_____