IRA M. DEMING, D.P.M.

DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY
PODIATRIC MEDICINE, SPORTS MEDICINE AND FOOT SURGERY

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ROCKVILLE, MD 20852
PHONE – 301 816-8681
FAX – 301 816-8684

PATIENT INFORMATION

(CONFIDENTIAL INFORMATION-IMPORTANT FOR OUR FILES AND YOUR HEALTH)

PATIENT ______________________________ DATE OF BIRTH ____________________

ADDRESS ____

CITY______________________________________ STATE __________ ZIP ___________

HOME PHONE ____________________ WORK PHONE __________________EXT________CELL PHONE___________________

e-mail address: ____________

MARITAL STATUS S M D W SEX M F

EMPLOYER ___________________________OCCUPATION ______________________

SOCIAL SECURITY NUMBER__________________RESPONSIBLE PARTY/ PARENT _______________________

EMERGENCY CONTACT ____________________PHONE NUMBER_____________________

WHO REFERRED YOU TO OUR OFFICE _____________________________________

HEALTH INFORMATION

FAMILY PHYSICIAN____

FORMER PODIATRIST ____________________ WHAT DID THEY TREAT YOU FOR __________________

WHAT IS YOUR CHIEF FOOT COMPLAINT? ______________________________________

LIST ALL MEDICATIONS YOU CURRENTLY TAKE ____________________________________

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LIST ANY SPORTS YOU PARTICIPATE IN ____

*INDICATE WHICH OF YOUR **RELATIVES** HAVE HAD THE FOLLOWING:*

CANCER ____________________ DIABETES ______________________ HEART PROBLEMS __________________

KIDNEY _____________________ ARTHRITIS ______________________STROKE ___________________________

HIGH BLOOD PRESSURE ___________________________________OTHER ________________________________

*INDICATE IF **YOU** HAVE HAD ANY OF THE FOLLOWING:*

VISION/HEARING PROBLEMS _________________ ALLERGIES TO FOOD/MEDICATIONS ___________________

THYROID ____________________________DIABETES _____________________SKIN _______________________

ANEMIA/BLEEDING ___________________HEART ________________________CIRCULATION _______________

HIGH BLOOD PRESSURE _______________KIDNEY ________________________STROKE ____________________

CHEST PAIN _________________________SHORTNESS OF BREATH ________LUNGS ______________________

LIVER/GALL BLADDER ________________STOMACH ULCER ______________ARTHRITIS __________________

BACK PROBLEMS ____________________ DOUBLE JOINTED ______________GOUT ______________________

SICKLE CELL _________________________ EXPOSURE TO HIV ______________ DRUG ABUSE ______________

DO YOU SMOKE? _____________________ DRINK ALCOHOL? _____________ OTHER ______________________

DO YOU EXPERIENCE CRAMPS,SWELLING OR NUMBNESS IN FEET OR LEGS? ___________________________

IS THERE ANYTHING YOU WISH TO TELL THE DOCTOR IN PRIVATE? ___________________________________

ARE YOU PREGNANT? __________________________

AUTHORIZATION TO BILL FOR SERVICES RENDERED

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/INSURANCE BENEFITS, MEDIGAP/SECONDARY INSURANCE, BE MADE TO ME OR ON MY BEHALF TO DR. IRA DEMING FOR ANY SERVICES FURNISHED BY THE PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION OR MEDICAL INSURANCE COMPANY AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS. IN ALL CASE, BILLS ARE THE RESPONSIBILITY OF THE PATIENT AND/OR GUARDIAN. ANY INSURANCE YOU MAY HAVE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ASK THAT YOU PAY YOUR PORTION AT THE TIME SERVICES ARE RENDERED. OUR ACCEPTANCE OF THE ASSIGNMENT OF BENEFITS DOES NOT RELIEVE YOU FROM YOUR OBLIGATION FOR THE FULL AMOUNT OF ALL SERVICES RENDERED. IN THE UNLIKELY EVENT YOUR ACCOUNT IS FORWARDED TO A COLLECTION AGENCY OR OUR ATTORNEY FOR COLLECTION, YOU AGREE TO PAY ALL COSTS OF COLLECTION AND ATTORNEY FEES OF 33 1/3% AND ANY RELATED EXPENSES AND COURT COSTS. I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE.

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SIGNATURE OF PATIENT, PARENT OR AUTHORIZED REPRESENTATIVE DATE