Richard T. Meredick , D.P.M. , P.C.

David J. Flannery, D.P.M.

Brian J. Kobylus, D.P.M.

Welcome to our practice . We all take great pride in our work and look forward to developing a positive doctor/patient relationship with you. Please carefully review and complete the forms below as they will help us in your evaluation and treatment plan. Thank You.

Today's Date:_____

PERSONAL INFORMATION:

Patient Name:_____ Male_____ Female_____

DOB:_____ Race: Afro-American _____Asian ____Caucasian ____Hispanic ____Other_____

Street Address:_____

City:_____ State:_____ Zip Code :_____

Phone#:(H)_____ (cell)_____ Work_____

E-Mail:_____

Place of Employment:_____ Is this a work related visit Y/N_____

SS#:_____ Family Doctor:_____

Preferred language:_____

INSURANCE INFORMATION:

Insurance #1:_____ ID#:_____

Group#:_____ Subscriber:_____ Subscriber DOB:_____

Insurance #2:_____ ID#:_____

Group #:_____Subscriber:_____ Subscriber DOB:_____

Patient Height:_____ Patient weight:_____

MEDICAL HISTORY:

On Going Medical Problems: __High Blood Pressure __High Cholesterol __Diabetes __Heart Disease

__Thyroid __COPD __CHF __A-Fib __Acid reflux __Cancer __Water Retention Other_____

Other_____

Past Surgical History:_____

_____

Medications/mgs:_____

_____

Social History: Do you smoke?_____ If yes, how many packs a day_____

Do you Drink alcohol?_____ if yes, _____occasional or _____ frequent

Please list Allergies:

Medications:_____

Reaction/Severity:_____

Food:_____

Reaction/Severity:_____

Enviromental:_____

Reaction/Severity:_____

REASON FOR BEING SEEN TODAY:_____

How did you hear about our office: (please check or fill out as indicated, thank you)

____Family Doctor ____Patient/Friend ____Insurance Carrier _____ Print Ad

Other: (please specify):_____

I authorize Drs. Meredick/Flannery/Kobylus to use this information for all insurance related purposes. I also believe that all the information contained herein is truthful to the best of my knowledge.

PATIENT SIGNATURE:_____

Richard T. Meredick, D.P.M., P.C.
David J. Flannery, D.P.M.
Brian J. Kobylus, D.P.M.

201 NORTH MAIN AVENUE
SCRANTON, PA 18504

TELEPHONE: (570) 342-4009

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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 understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature