

HOWARD HOROWITZ, DPM

Medicine & Surgery of the Foot

BOWIE FOOT CARE

17000 Science Drive, Suite 104

Bowie, MD 20715

301-464-5900

NEW PATIENT INFORMATION**PATIENT INFO**

Today's Date _____

Name _____ Age _____ Date of Birth _____

Address _____ Home Phone _____

Work Phone _____

Email Address _____

Place of Employment _____ Social Security # _____

If child, list parent's first name: Father _____ Mother _____

Insurance Company: Medicare BC/BS of NCA BC/BS of Maryland other insurance company**Primary****Secondary, if applicable**

Insurance Co. Address _____

Address _____

Insurance Co. Phone _____

Phone _____ Employer _____

Policy Holder _____

Policy Holder _____

Policy Number _____

Policy Number _____

Group Number _____

Group Number _____

Policy Holder's Date of Birth _____

Policy Holder's Date of Birth _____

Policy Holder's S.S. No. _____

Policy Holder's S.S. No. _____

Relationship to insured: self spouse child

Your preferred pharmacy _____ Street/City _____ Phone _____

Who should we thank for referring you to our office? Doctor Patient Family Friend Phone book Other

Name/Source _____

Insurance Authorization and Assignment

Please remember insurance is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, COPAY, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE. We request that these charges be paid at the conclusion of each visit. If it becomes necessary for this account to be turned over for collection, you will be responsible for all related costs as well as any balance due.

I hereby authorize any holder of medical and/or other information about me needed to determine benefits for related services to release such information to the Centers of Medicare & Medicaid Services or other insurance companies.

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and other health plans to Howard Horowitz, DPM. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Patient's Signature _____ Date _____

If minor, Parent/Guardian signature: _____ Relationship _____ Date _____

Patient Name _____

Date _____

Today's foot complaint: _____ Duration _____

2nd foot complaint: _____ Duration _____

Foot Health: Circle if you have ever been treated for:

Corns/calluses	Warts	Athlete's foot	Leg or foot ulcers
Fungal nails	Ingrown nails	Flat feet	Neuroma
Broken bones	Ankle sprain	Foot numbness	Rash
Bunions	Arch pain	Hammertoes	Knee pain
Heel pain	Lower back pain	Childhood foot problems	Gait (walking) problems
Cramps in legs/feet	High arch feet		

Are your first steps out of bed painful? _____ Then subsides? _____

Do you get leg cramps during the day? _____ At night? _____

Any pain in calves or buttocks when walking? _____ Is it relieved by stopping & standing still? _____

List the sports/type of dance you are active in _____

Your type of job activity/occupation _____ Hours per day on feet _____

Shoe size _____ Weight _____ lbs Height _____ ft _____ in

General Health History: Circle if you now or have you ever been treated for:

Stroke	Heart attack	High blood pressure	Phlebitis
Vascular disease	Heart condition	Diabetes	Poor circulation
Headache	Hepatitis	Liver disease	Anemia
Gout	Lyme's disease	Arthritis	Osteoporosis
Sciatica	Rheumatic fever	Alzheimer's	Epilepsy
Keloid/thick scar	Nerve disorder	Hearing/ear disorders	Glaucoma
Psychiatric disorder	Kidney disease	Thyroid problem	Asthma
Lung disease	Tuberculosis	Stomach ulcer	Cancer
Other _____			

Your general physician _____ Phone Number _____

Do you have joint implants? _____ Do you have history of heart valve problems? _____

List major surgery _____ Date _____

_____ Date _____

Other hospitalizations _____ Date _____

_____ Date _____

Are you allergic to any of the following? Please circle

Penicillin	Codeine	Demerol	Novocain	Aspirin	Advil
Aleve	Sulfa Drugs	Motrin	Adhesive Tape	Other _____	

List current medications _____

Drink alcoholic beverages? None Rarely Moderately Daily Quit

Use recreational drugs? None Rarely Moderately Daily Quit

Smoke? _____ packs/day for _____ years