

MEDICAL AND PODIATRY INFORMATION

Foot Problem _____

Family Doctor _____ Date of Last Visit _____

Doctor's Address _____ Doctor's Phone # _____

1. Are you in general good health? Yes _____ No _____
2. Have you been treated for Diabetes? Yes _____ No _____
3. Have you had any serious Illness or Operation? Yes _____ No _____
4. Are you allergic to any of the following? Novocaine _____ Penicillin _____ Adhesive Tape _____ Others _____
5. Have you ever been treated for any of the following? Stomach/Bowel _____ High Blood Pressure _____
Heart Problems _____ Asthma _____ Epilepsy _____ Rheumatic Fever _____
Kidney Problems _____ Liver Problems _____ Arthritis _____ Bursitis _____
6. Present medication being taken _____

I hereby give my permission to Dr. David Charnota and his Associates to administer treatment and to perform procedures as may be deemed necessary in the diagnosis and/or treatment of my (or my dependent's) foot condition.

I, the undersigned, assign all payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am financially responsible for charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of the signature on all insurance submissions.

Signature _____ Relationship _____ Date _____

PATIENT'S AGREEMENT

I understand that it is my responsibility to provide the proper insurance information/card necessary to secure payment for any services furnished me by provider. Should I fail to inform you of this at the time of visit, I agree to be personally and fully responsible for payment. I also understand that it will be my responsibility to obtain reimbursement from correct insurance carrier.

Signature Of Patient/Responsible Party _____