HARFORD FOOT and ANKLE CENTER, P.A. TODAY'S DATE______________.

ROY S. DANSKY, DPM 824 South Main Street- Bel Air, Maryland 21014-4112 410-836-9667

Last Name First Name M.I. Street Address Apt. #

City State Zip Home Phone # Cellular Phone # email address

Last 4 Numbers SS# Date of Birth Age Marital Status: M S W Sep Div.

Employer's Name Employer's Address City, State Zip Work Phone #

Student: Part time/ Full time School Phone # Name of School Address, City, State, Zip

Spouse's Name Emergency Contact, Other than Spouse Phone # Relationship

Financially Responsible Person (if Different from Patient) Their Address Their Home phone number

How did you hear about our Practice? Verizon Yellow Pages / Red Book / Yellow Book / Sign / Doctor's Referral / Other Patient / Office's Website (Thru Google/Yahoo/Bing)/ Friend / Insurance Co. / Insurance Co. Web Site/ Other _______________

Referring Friend's Name Referring Physician's Name

Your Primary Physician's Name Physician's Phone # Last Time You Saw Your Doctor

INSURANCE COVERAGE INFORMATION

Primary Ins. Co. Name of Policy Holder Relationship Policy Holder's Birthday Policy I.D. # Group #

If Spouse or Parent is the Policy Holder, Please write their Employer's Name Employer's Phone #

Secondary Ins. Co. Name of Policy Holder Relationship Policy Holder's Birthday Policy I.D. # Group #

If Spouse or Parent is the Policy Holder, Please write their Employer's Name Employer's Phone #

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Harford Foot and Ankle Center, PA for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and agents any information needed to determine these benefits or benefits payable for related services. I agree to allow the doctor to perform an examination, take x-rays, and give injections and I am aware that complications may arise with any procedure.

Signature Date

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to Harford Foot and Ankle Center, PA, for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by the contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided me. This information will be used for the purpose of evaluating and administering claim of benefits. I permit a copy of this authorization to be used in place of the original . I agree to allow the doctor to perform an examination, take x-rays, and give injections and I am aware that complications may arise with any procedure.

Signature of Subscriber or Beneficiary Date

NAME:____________________ **DATE:** _________

MEDICAL HISTORY

Reason for Visit.:____

____

1. Date when Condition Started:____

2. Is the Condition Injury Related: YES NO If Yes location of Injury: AUTO SPORTS WORK OTHER:_________________

3. What Symptoms are You Experiencing:____

____

4. Have You Had Similar Symptoms Previously?: YES NO

5. Have You Been Seen by Another Physician or Medical Facility for This Condition? YES NO
   IF YES: A. Name of Physician/ Podiatrist:____
   B. Name of Medical Facility:____
   C: Test Performed: X-RAY BONE SCAN CAT SCAN MRI EMG ULTRASOUND BLOOD WORK
   (circle)

6. Circle Any Treatment (s) You Had for This Problem: MEDICATIONS CORTISONE INJECTION ORTHOTICS SURGERY PHYSICAL THERAPY EXERCISES CAST/ BRACE OTHER:____________

7. Do You Have Any Medical Problems? YES NO
   IF YES:____

____

8. Have you Ever Had Any Surgery in the Past? YES NO IF YES, Please List (Including Date)

____

____

9. Are You Currently Taking Any Medications? YES NO
   IF YES, Please List:____

____

10. **Do You Have Any Medication Allergies?** YES NO **IF YES, Please List**:________________________________

11. **Weight:**___________**(very important)** **Height**:_______________________ Shoe Size:______________________________

12. Do You (Circle) SMOKE TOBACCO DRINK ALCOHOL If Yes, How Much/ How Many Years?__________________

13. Do You Experience Abnormal Bleeding with Surgery, Cuts Extractions, Trauma, Menstration? YES NO

14. Are You, or is There Any Chance You Are Pregnant? YES NO

15. Are you nursing? YES NO

Check If You Now Have, or Were Treated For Any of the Following:

___DIABETES
___HIGH BLOOD PRESSURE
___HEART DISEASE
___STROKE
___CHEST PAIN
___BREATHING PROBLEMS
___ASTHMA
___POOR CIRCULATION
___KIDNEY DISEASE
___LIVER DISEASE
___THYROID DISEASE
___RHEUMATIC FEVER
___VENEREAL DISEASE
___BLEEDING TENDENCY
___DELAYED HEALING
___NERVOUS CONDITION
___BROKEN BONES
___GLAUCOMA
___ TB
___ULCERS
___ PREVIOUS FOOT PROBLEMS
___GOUT
___OTHER__________________________
___ANEMIA
___CANCER
___ALLERGIES
___EPILEPSY
___ARTHRITIS
___HIV +
___DEPRESSION

Check If Any Family Members (Blood Relatives) Have Had Any of the Following:

___DIABETES
___ARTHRITIS
___KIDNEY DISEASE
___FOOT PROBLEMS SIMILAR TO YOURS
___GOUT
___HEART DISEASE
___HIGH BLOOD PRESSURE
___TB
___STROKE
___CANCER

NAME:__________________________

REVIEW OF SYSTEMS

Please identify any symptoms below that you are **currently** experiencing by circling them or writing them in the "Other" field. If you are **not** experiencing any symptoms, please **circle "NONE"**.

GENERAL

Chills
Fatigue
Fever
Night Sweats
Recent Weight Loss/Gain
Other:_______________
NONE

CARDIOVASCULAR

Chest Pain
Murmurs
Palpitations
Other:________________
NONE

RESPIRATORY

Difficulty Breathing
Persistent Cough
Shortness of Breath
Other:_________________
NONE

GI

Abdominal Discomfort
Blood in Stool
Constipation
Diarrhea
Nausea/Vomiting
Other:_______________
NONE

GU

Blood in Urine
Incontinence
Painful Urination
Urinary Frequency
Venereal Disease
Other:_________________
NONE

MUSCULOSKELETAL

Body Aches
Joint Pain
Muscle Soreness
Muscle Weakness
Other:_________________
NONE

ENT

Difficulty Swallowing
Hearing Loss
Pain in Ears
Runny Nose
Sore Throat
Other:_______________
NONE

EYES

Blurred Vision
Double Vision
Other:_________________
NONE

SKIN

Dry
Itchy
Rash
Other:_________________
NONE

NEUROLOGICAL

Dizziness
Headaches
Slurred Speech
Tingling Sensation
Other:________________
NONE

PSYCHIATRIC

Anxiety
Depression
Difficulty Sleeping
Mood Changes
Other:_________________
NONE

SIGNATURE:_________________________________ **DATE:**_____________________________