NEW PATIENT PAPERWORK

First Name:_____

Middle Initial:_____

Last Name:_____

Gender:_____Male_____Female

Social Security#_____-_____-_____

Birthday: Month_____Date_____Year_____

Age:_____

Email Address:_____

Street Address:_____

City:_____

State:_____Zip:_____

Home Phone: _____

Work Phone:_____

Cell Phone:_____

Primary Care Physician:_____

Date Last Seen:_____

Primary Language:_____

Race: ____White
____American Indian or Alaska Native
____Asian
____Black or African American
____Native Hawaiian or other Pacific Islander

Emergency Contact:_____
Emergency Phone:_____

How did you hear about us:
____Referred by Doctor_____
____Internet
____Insurance Company
____Friend:_____
____Radio Ad
____Other:_____

Marital Status:
____Divorced
____Married
____Partner
____Single
____Widowed
____Legally Separated

Student Status:
____Full Time Student
____Part Time Student
____Not a Student

Employment Status:
___Employed Full time
___Employed Part time
___Not Employed

Okay to Leave a Message With:
___Patient Only
___Patient and/or Spouse
___Anyone Answering Phone

Ethnicity:
___Not Specified
___Hispanic or Latino
___Not Hispanic or Latino

PATIENT AUTHORIZATION: **I authorize Richard Silverstein, DPM to apply for benefits on my behalf for services rendered by Richard Silverstein, DPM. I request payment from my insurance company be made directly to Richard Silverstein, DPM. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.**

_____ _____

Signature of Subscriber or Beneficiary Date

INSURANCE INFORMATION

PRIMARY

Company: _____

Insured Name: _____

Relationship: _____ DOB: _____

Co-Pay amount: _____

Policy Number: _____

Group Number: _____

Employer: _____

SECONDARY

Company: _____

Insured Name: _____

Relationship: _____ DOB: _____

Co-Pay amount: _____

Policy Number: _____

Group Number: _____

Employer: _____

Guarantor Information (PRIMARY INSURANCE HOLDER)

Guarantor : _____

Address : _____

City : _____ State: _____ Zip code: _____

Telephone # : _____ Cell #: _____

Patient's Authorization

I authorize RICHARD J SILVERSTEIN, D.P.M. to apply for benefits on my behalf for services rendered by RICHARD J SILVERSTEIN, D.P.M. I request payment from my insurance company be made directly to RICHARD J SILVERSTEIN, D.P.M. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is provided.

_____ _____

Signature of Subscriber or Beneficiary Date

MEDICAL HISTORY

Patient Name: _____ NONE ☐

GENERAL

__ Weight Loss
__ Fatigue
__ Fainting
__ Chronic Illness
__ High Blood Pressure

EYES

__ Glaucoma
__ Cataracts
__ Macular Degeneration
__ Wear glasses
__ Blurred Vision

EARS, NOSE, MOUTH & THROAT

__ Headaches
__ Dizziness
__ Ear Ringing
__ Balance difficulties
__ Seasonal allergies
__ Chewing Problems/Swallowing Problems
__ Hoarseness/chronic sore throat

HEART

__ Heart Attack
__ Angina/Chest Pain
__ Heart Valve problems
__ Irregular Heart Beat
__ Hypertension

LUNGS

__ Shortness of breath
__ Asthma
__ Chronic Bronchitis
__ Emphysema

STOMACH

__ Acid Reflux
__ Stomach Ulcer
__ Constant Vomiting
__ Constant thirst or hunger

ABDOMINAL

__ Bladder Problems
__ Hiatal Hernia
__ Bloody Discharge
__ Constipation
__ Diarrhea
__ Kidney Problems

MUSCULOSKELETAL

__ Arthritis
__ Knee pain
__ Back pain
__ Hip pain
__ Gout
__ Arm pain
__ Shoulder pain

SKIN

__ Rashes
__ Moles
__ Abnormal lesions
__ Skin Cancer Type _____
__ Nail disorders

NEUROLOGICAL

__ Stroke
__ Mini-stroke
__ Muscle Weakness
__ Abnormal walking

PSYCHOLOGICAL

__ Depression
__ Anxiety
__ Bipolar disorder
__ Drug/Alcohol dependence

ENDOCRINE

__ Diabetes
__ Thyroid Disease
__ High Cholesterol

BLEEDING

__ Sickle Cell Anemia
__ Bleeding disorder
__ Blood Cancer
__ Sexually Transmitted Disease

__ HIV/AIDS
__ Hepatitis B
__ Hepatitis C

ALLERGIES

__ Seasonal allergies
__ Drug Allergies
__ Anesthesia

ALLERGIES & MEDICATIONS

ALLERGIES:

LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS: NONE ☐

____ Penicillin ____ Sulfa ____ Local Anesthetic ____ Tape ____ Iodine on Skin ____Codeine

____ Anti-inflammatory Medication ____ Nausea from Anesthetic Other_____

MEDICATIONS:

List all prescriptions and over the counter medications with dosages and the reason why they are being prescribed.

NONE ☐

MEDICATION	DOSAGE	REASON FOR TAKING

SHOE SIZE _____ HEIGHT _____ WEIGHT _____
DO YOU DRINK? ___ NO ____YES DRINKS PER WEEK _____
DO YOU SMOKE? ___ NO ____ YES PACK(S) DAY? _____
ILLEGAL DRUG USE? ___NO___YES

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information for you. I will notify the doctor of any changes in my health or medications.

Patient/Guardian Signature: _____

History Reviewed by Dr. Silverstein: _____

RICHARD J. SILVERSTEIN, DPM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The office of Dr. Richard Silverstein is dedicated to preserving the privacy of your protected health information. We are requesting this Patient Authorization to give you notice of our privacy practices and how we may use and disclose protected health information about you.

We are requesting that you acknowledge receipt of the following Privacy Practices by your signature below:

1. We may ask you to sign your name on a list of patients and will call your name out loud in our public waiting room;
2. We may call your home or work to remind you of upcoming appointments, inform you of test results, or ask you to return our call. In the event that you are not there, we may leave a message on an answering machine or with the individual who answers the phone;
3. We may receive and send your protected health information, including test results, pathology, radiology reports and prescriptions, electronically, by fax and by telephone, to your health care providers, laboratories, pharmacies and insurances carriers.

We reserve the right to change the terms of our above described Privacy Practices by notice to you at your next visit to this office. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you provided it is in writing and signed by both of us.

By signing this form, you consent to our use and disclosure of your protected health information. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I, the undersigned patient, request that payment of authorized insurance carrier benefits be made on my behalf to Dr. Richard Silverstein for any services furnished to me by him or his office. I authorize any holder of medical information about me to release to the centers of Medicare/Medicaid Services and its agent and/or other insurance carriers for which I have coverage, and information needed to determine these benefits payable for related services. I agree to provide all referral and treatment plans as required by my insurance carriers. All copays must be paid at the time of service in accordance with the contract insurance carrier agreements.

_____ _____

Signature of Patient Date