ROBERT J. KAPLAN, DPM
1901 Hay Terrace, Easton, PA 18042

# PATIENT REGISTRATION

Name: ______________________________________________ Age: ______ Date: ___________
First Middle Last

Address: ___________________________ City: _________________ State: _____ Zip: ______

Home Phone: ______________ Work Phone: __________________Cell Phone: _________________

Employer: ____________________ Address: ____________________________________

Sex: M ____ F ____ Birth date: ___________ SS# ____________Marital Status: S M D W Sep.

Name of Spouse or Parent: _____________________________________ Relationship: ____________

Home Phone: ________________________ Work Phone: _____________________________

Address: __________________________________________________________________

Emergency Contact: ____________________________________ Relationship: __________________

Home Phone: ________________________ Work Phone: _____________________________

Address: __________________________________________________________________

Family Physician: ____________________ Address: _____________________________________

Physician's Phone : ____________________ Date Last Seen: _________________________________

Pharmacy Name & Address: ____________________________________________________________

Pharmacy Phone: _______________ How Did You Hear About Our Office? ______________________

# PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_______________________________________________________________________________

_______________________________________________________________________________

Have you ever been to a Podiatrist before? Yes __________ No ________

If Yes, please list Doctor's name: ____________________________ Last Visit: _____________________

## PAST MEDICAL HISTORY

PLEASE CHECK

| | | | |
|---|---|---|---|
| ______ Diabetes | ______ Asthma | ______ Heart Disease | ______ High Blood Pressure |
| ______ Anemia | ______ Arthritis | ______ Epilepsy | ______ Bleeding Disorder |
| ______ Gout | ______ Stomach Ulcers | ______ Blood Clots | ______ Kidney Problems |
| ______ Liver Problems | ______ Tuberculosis | ______ Cancer | ______ High Cholesterol |
| ______ Lung Problems | ______ Thyroid | ______ Stroke | ______ Circulatory Problem |
| ______ Hepatitis | ______ HIV/AIDS | _________________________ | Other |

What SURGERIES have you had? ___________________________________________________________

What MEDICATIONS do you take regularly? (Include prescriptions, over-the-counter medications and vitamins.)

_____________________________________________________________________________________

_____________________________________________________________________________________

Do you have any ALLERGIES to MEDICATIONS? Yes _____ No ________

If yes, what are they? ____________________________________________________________________

## INSURANCE

Who is responsible for this account? ___________________ Relationship to patient: ________________

Insurance Company: ______________________________________________________________

Subscriber Name: ____________________________ Relationship to patient: ______________________

Subscriber's Birth date: _____________________________ SS# ________________________________

Member ID # ________________________________ Group # ___________________________________

Patient's Name ______________________________________________________________

Is patient covered by additional insurance? _______ Yes _______ No

Insurance Company: __________________________________________________________

Subscriber Name: ____________________________ Relationship to patient: ______________________

Subscriber's Birth date: _______________________ SS# ______________________________________

Member ID # _______________________________ Group # ___________________________________

## ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have/has insurance coverage and I assign directly to Robert J. Kaplan, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

| ______________________________ | ______________________________ | ______________________ |
|---|---|---|
| Patient / Responsible Party Signature | Relationship | Date |

## MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Robert J. Kaplan, DPM for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

| ______________________________ | ______________________________ | ______________________ |
|---|---|---|
| Patient / Responsible Party Signature | Relationship | Date |