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: _____

Patient Name _____

Please continue ->

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 Problems
_____ 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 # _____

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 _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that I have received a copy of Robert J. Kaplan, DPM's Notice of Privacy Practices. This notice describes how Robert J. Kaplan, DPM may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights I may have regarding my protected health information.

Patient / Responsible Party Signature _____ Date _____

Relationship to Patient _____

Please Print Patient's Name _____

DR. ROBERT J. KAPLAN

1901 Hay Terrace, Easton, PA 18042-4650

COMMUNICATION CONSENT

It is the office policy of Dr. Robert J. Kaplan and staff not to release confidential and/or authorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls, information will not be left with an unauthorized person who may answer the telephone.

I authorize Dr. Robert J. Kaplan and his staff to leave information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home telephone number: _____ Yes _____ No _____

Answering machine Yes _____ No _____

Work telephone number: _____ Yes _____ No _____

Voice mail at work Yes _____ No _____

Cell phone number: _____ Yes _____ No _____

Pager number: _____ Yes _____ No _____

Email address: _____ Yes _____ No _____

Fax medical records for referrals to another entity:

_____ Yes _____ No _____

If you would like to have information released to someone other than yourself, please complete the following:

Please list names of authorized people:

Spouse: _____ Yes _____ No _____

Employer: _____ Yes _____ No _____

Disability insurance: _____ Yes _____ No _____

Other entities or people (list names and relationship to you):

_____

_____

_____

Patient's Printed Name: _____

Patient/Guardian Signature: _____ Date: _____