PATIENT REGISTRATION & HISTORY FORM

GREGORY S. MARKANTONE, DPM, PC

PATIENT INFORMATION Date ______/______/________

Patient Name ____
First Last M.I.

Street ____

Address ____
City State Zip Code

Home Phone# ( ) _______- _______

Male _____ Female ______ / AGE ________ Date of Birth ______/______/________

Single _____ Married _____ Widowed _____ Divorced _____

Patient SS# _______/_______/_______ Occupation _____________________________________

Employer__________________________________ Address ______________________________

Work Phone# _____________________________

Spouse's Name ____________________________________ Date of Birth ______/______/________

Spouse's SS# _______/_______/_______

Spouse's Employer _________________________________ / Occupation ______________________

Work Phone# ( ) _______ - ________

Email Address ____

IN CASE OF AN EMERGENCY, CONTACT

Name ____________________________________ Relationship ______________________________

Home Phone# ( ) _______ - _______ Work Phone ( ) _____ - ________

Who is responsible for this account? _____________________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I or my dependent) have insurance coverage with ___________________________ and assign directly to Dr. Markantone all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes 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.

____ / ____________________________
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf of Dr. Markantone 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 agent 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 change determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ / ____________________________
Beneficiary Signature Date

List Any Known Allergies ____

List Current Medications ____

o Fill in this circle if you do not permit us to download your medications

Are you currently taking a Birth Control Pill? Yes ______ No ______

Pharmacy Name ___________________________ Pharmacy Ph# (_______) ________-_________

Family Physician ________________________________Date Last Seen _____________________

Are you now, or have you been, under any other doctor's care for any reason over the past two years?
Yes ______ No ______

If Yes, please explain ____

Height: ______ Ft. ______Inches / Weight: ________ / Shoe Size: ________

SOCIAL HISTORY

Cigarette Use ______ How Much? ____________
Chewing Tobacco ______
Alcohol Use ______ How Much? ____________
Marital Status (circle one)
Single Married Separated Divorced Widowed
Occupation ____

FAMILY HISTORY (Circle all that apply)

(Relationship to You)

Arthritis	Cancer	Diabetes	Gout
Heart Problems	Kidney Disease	Psychiatric Illness	Stroke

PAST SURGICAL HISTORY

List all Surgeries you have had: ____

____

PAST MEDICAL HISTORY (Circle All That Apply) or (none)

CARDIOVASCULAR
- Heart Disease
- Hypertension

ENDOCRINE HISTORY
- Diabetes
- Hypothyroidism
- Obesity

HEMATOLOGIC HISTORY
- Blood Clotting Abnormalities
- Hepatitis
- Sickle Cell
- Jaundice

GASTROINTESTINAL HISTORY
- Ulcer

PSYCHIATRIC HISTORY

Depression
History Psychiatric Problems

RESPIRATORY HISTORY
- Asthma
- COPD

NEUROLOGIC HISTORY
- Neuropathy
- Seizure
- Stroke

MUSCULOSKELETAL HISTORY
- Arthritis Conditions
  - List ____________________
- Back Pain
- Gout

CHILDHOOD ILLNESSES
- Asthma

REVIEW OF SYSTEMS (Circle all that apply) or (none)

ALLERGIC / IMMUNOLOGIC
- Hepatitis
- HIV/AIDS

CARDIOVASCULAR
- Ankle Swelling
- Cold Feet
- Shortness of Breath

CONSTITUTIONAL SYMPTOMS
- Unexpected Weight Changes
- Anxiety

RESPIRATORY
- Difficulty Breathing
- Chest Pain
- Shortness of Breath
- Sleep Apnea

EYES
- Blurred Vision
- Dry Eyes

NEUROLOGICAL
- Balance Problems
- Vertigo
- Numbness
- Paresis (muscle weakness)

EAR, NOSE, MOUTH, THROAT
- Ear Pain
- Ringing in the Ears
- Nasal Pain
- Mouth Pain

ENDOCRINE
- Diabetes
- Hypothyroidism

GASTROINTESTINAL
- Chronic Diarrhea
- Gastrointestinal Ulcers
- Stomach Problems

HEMATOLOGIC
- Blood Clotting Problems
- Sickle Cell

INTEGUMENTARY
- Athlete's Foot
- Foot Ulcer
- Leg Ulcer
- Skin Cancer

GENITOURINARY
- Chance of Pregnancy
- Painful Urination

MUSCULOSKELETAL
- Back Pain
- Joint Pain
- Muscle Pain
- Gout Attack

PSYCHIATRIC
- Addiction to Alcohol
- Addiction to Drugs
- Depression
- Panic Attacks

PODIATRY HISTORY

What problems brings you to our office? ____

How long has this existed? ____

Can you recall any event when this started ____

Has this condition been getting better, worse or the same? ________________________________

Treatments you have done in the past ____

Are your symptoms worse after standing?	Yes ______	No ______
Are your symptoms worse after walking?	Yes ______	No ______
Are your symptoms worse after wearing shoes?	Yes ______	No ______
Do your symptoms affect your work or sports activties?	Yes ______	No ______
Are your required to wear special foot gear?	Yes ______	No ______
Do you spend more than 50% standing at work?	Yes ______	No ______
Do you experience burning, numbness or tingling in your feet or legs?	Yes ______	No ______
Do you experience corns or calluses?	Yes ______	No ______
Has anyone in your family ever had foot problems similar to yours?	Yes ______	No ______
Have you been treated by a doctor for your foot condition?	Yes ______	No ______

If Yes, please describe: ____

____

Former Podatrist: ____
Name

Why and when did you last see a podiatrist? ____

Patient's Signature: ____ Date: ________________

Whom may we "Thank" for referring you to our Office? ________________________________

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of me.

Signature:____ Date ________________________

Guardian's Signature (if under 18 yrs of age)____

DR. GREGORY S. MARKANTONE, DPM, PC
3863 ROUTE 30
LATROBE, PA 15650

FINANCIAL STATEMENT

The following information is provided to all patients to avoid any misunderstandings or disagreement concerning payment for professional services. With all of the recent changes in healthcare (high deductibles and co-payments) our office needs to make changes in order to continue to provide you with the comprehensive state-of-the-art healthcare you deserve.

By law, all patient accounts are due and payable within 30 days of services rendered. If you have health insurance coverage for services provided, that is a contract between you and your insurer. It is your responsibility to ensure that they remit payment and that you remit payment for any services not covered. If you are self-paying for your services, all payments are due when services are rendered.

If you subscribe to a managed care plan, you may be required to obtain a referral from your primary care physician before seeking treatment from a specialist. It is important to bring your referral with you or to verify that it was completed prior to your appointment. We will submit all claims to your insurance carrier and will accept their "allowance" as full payment, excluding deductibles, coinsurance, and co-payments, which will be the patient's responsibility. All patients are required to establish financial arrangements for payment on their account.

For your convenience sign up below for automatic electronic payment. (Optional)

ELECTRONIC PATIENT PAYMENT AUTHORIZATION

I consent and permit the above named merchant to charge my credit/debit card account the amount due for services rendered.

Name As Shown on Card ____ Card Type ___Visa ____MC ____Discover

Card# __________-__________-__________-___________ Expiration Date ___________/___________ Security Code _______

If you experience a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.

All unpaid balances over 90 days will be subject to further collection action, with a $25 service fee added to the balance, unless payment arrangements have been made. Please notify us immediately if you feel an error appears on your statement. Any checks returned for non-sufficient funds will be subject to a $35 fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you may have concerning your balance. If you have any questions concerning our policy or need assistance, please contact us immediately.

The current cost (subject to change) for copying medical records are as follows:

$ 8.00 Per x-ray film	$16.24 Search and retrieval fee, applies to all requests
$1.09 Per page for the first 20 pages	$0.82 Per page for pages 21-60
$0.28 Per page for pages 61 and over	Actual cost for postage and delivery applies to all requests

My signature below indicates that I have read the above statement and understand the contents of this informational letter.

____ _______________________

Patient's Signature Date

DR. GREGORY S. MARKANTONE, DPM, PC

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

______________________________ ______________________
Patient Name (please print) Date

____
Parent of Authorized Representative (if applicable)

DISCUSSION OF MEDICAL TREATMENT

Please list the family members or other person(s), if any, whom we can discuss your medical condition and your diagnosis ***(Your Social Security Number must be known to this person(s) in order for our office to access confidential information).***

Name: ______________________ Relationship to You: ______________

Name: ______________________ Relationship to You: ______________

Name: ______________________ Relationship to You: ______________

Name: ______________________ Relationship to You: ______________

Name: ______________________ Relationship to You: ______________

Signature: ____