PATIENT & MEDICAL INFORMATION

NAME:_____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER (last 4):_____

ADDRESS:_____ APT #_____

CITY_____ STATE_____ ZIP_____

TELEPHONE NUMBER:_____

2ND ADDRESS:_____ APT #_____

CITY_____ STATE_____ ZIP_____

TELEPHONE NUMBER:_____

MARRIED____ SINGLE_____ WIDOWED_____ DIVORCED____

YOU WERE REFERRED TO US BY? (circle one)

Internet search | Yelp | Facebook | Natural Awakenings

Drive by | Other Physician_____ Lecture | Friend/Family

E-mail :_____

I request that payment of Medicare/Medigap Benefits be made for any services furnished to me by Richard J. Rimler, DPM. I understand my signature authorizes the release of medical information necessary to pay the claim. Richard J. Rimler, DPM agrees to accept Medicare assignment and many other third party insurances, but I am responsible to pay any deductible and coinsurance, and for non-covered services. I am also responsible for any legal or recovery costs.

SIGNATURE:_____ DATE:_____

FAMILY DOCTOR:_____

FAMILY DOCTOR'S PHONE NUMBER:_____

CHECK IF YOU HAVE:

DIABETES____	CANCER____	HEPATITIS____
HEART DISEASE____	POOR CIRCULATION____	STROKE____
HIGH BLOOD PRESSURE____	GOUT____	ANEMIA____

NERVE DISORDER____

OTHER:_____

LIST ANY SURGERY:_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

DRINK ALCOHOL DAILY?____ SMOKE?_____

ARE YOU ALLERGIC TO:

PENICILLIN____	ASPIRIN____	SULFA____
ADHESIVE TAPE____	IODINE____	

OTHER_____

_____

The above information is accurate to the best of my knowledge.

SIGNATURE_____ DATE_____

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 choose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative

_____

Signature