Quakertown Foot Care Center

Stacy Ziskowski, DPM Frank Ziskowski, DPM, FACFAS, FACFAOM

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION

I authorize QFCC to release any medical information requested by representatives of local, state or federal agencies or insurance companies for payment of claims rising of this foot care that are due to Quakertown Foot Care Center

_____ (initial)

INSURANCE ASSIGNMENT

If I am entitled to benefits under Medicare, Medicaid or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me) in consideration for services provided to me by Quakertown Foot Care Center, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Quakertown Foot Care Center, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any co-insurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified or not pre-authorized by my insurance plan.**

_____ (initial)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have received, read and understand the *Notice of Privacy Practices*. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of *the Notice of Private Practices*

To the best of my knowledge, I have answered the questions on these forms as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status.

Responsible Party Signature: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____

Quakertown Foot Care Center

Stacy Ziskowski, DPM Frank Ziskowski, DPM, FACFAS, FACFAOM

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ Marital Status: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Employer: _____ Occupation: _____ Work Phone #: _____

Shoe Size: _____ Height: _____ Weight: _____ Sex: Male Female

Emergency Contact: _____

Emergency #: _____ Relationship to Patient: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Pharmacy Name: _____ Phone #: _____

Address: _____

How did you hear about Quakertown Foot Care Center?

_____

_____

445 S. West End Blvd. Quakertown, Pa 18951 (215) 538-3668

Quakertown Foot Care Center

Stacy Ziskowski, DPM Frank Ziskowski, DPM, FACFAS, FACFAOM

MEDICAL HISTORY

Name: _____ Date: _____

Please list any specific problems that you would like to discuss with the doctor: _____

_____

How long have you had this problem? _____

Is there a history of injury? _____ Date of Injury: _____ Is this a work-related injury?_____

Is the condition getting worse, getting better or the same? _____

Do you have currently or have had a history of any of the following? *Please circle all that apply*

High Blood Pressure	Diabetes	Cerebral Palsy	Ulcerative Colitis/Crohn's
Stroke/TIA	Multiple Sclerosis	Rheumatoid Arthritis	Lyme Disease
Angina/Heart attack	Heart Failure	Spinal Cord Injury	Liver Disease/Hepatitis
Heart Rhythm Disorder	Kidney Disease/Dialysis	Seizure/Epilepsy	Back Trouble/Sciatica
Heart Failure	Neuropathy	Panic/Anxiety Disorder	HIV/AIDS
Muscular Dystrophy	Thyroid Disorder	Bipolar/Depression	Dementia/Alzheimer's
Asthma/COPD	High Cholesterol	Blood Clot in Vein	Osteoarthritis
Pulmonary Embolism	Bleeding tendency	Stomach Ulcers/Acid reflux/GERD	Cancer:_____
Psoriasis	Lupus/SLE	Gout	Other:

Are there any common diseases/conditions that run in your family? _____

_____

Please list all previous **hospitalizations**: _____

Please list all previous **surgeries**: _____

Please list all current **medications**: _____

_____

Allergies: ___ None ___Penicillin ___Sulfa ___Aspirin ___Contrast Dye ___Latex ___Iodine ___Shellfish ___Adhesive ___Tape ___ Metal ___ Food Allergies:_____ Other: _____

Social History:

Do you ever drink alcohol? ___ Yes ___ No ___ Not anymore How often/how much? _____

Have you ever used tobacco? ___ Yes ___ No ___ Quit Amount per day: _____ Age began: _____

***Women**: Could you be pregnant now? ___ Yes ___ No Are you breastfeeding? ___ Yes ___ No*

Signature of Doctor: _____ Date: _____

445 S. West End Blvd. Quakertown, Pa 18951 (215) 538-3668