*Cheralyn Perkins, DPM • David Scalzo, DPM • Kathleen Hope, DPM*
*Simon G. Tabchi, DPM • Jason Eberly, DPM*


BANGOR
325 Blue Valley Drive
Bangor, PA 18013
Ph: (610) 588-6621 • Fax: (610) 588-6307

BRODHEADSVILLE
1636 Rt 209 BK Plaza, Unit 1
Brodheadsville, PA 18322
Ph: (570) 992-5779 • Fax: (570) 992-5806

ALLENTOWN
451 Chew Street, Suite 306
Allentown, PA 18102
Ph: (610) 351-9244 • Fax: (610) 351-9247


**Name:** ______________________________________________ **Date:** ______________
*(First, Middle, Last)*

**Date of Birth:** ______________________ **Sex:** M F

**Social Security #:**______________________

**Race/Ethnicity:**__________________________ **Language:**______________________

**Height:** ______________ **Weight:** ______________ **Shoe Size:**__________________

**Address:** ______________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Phone Numbers**

Home: ________________________ Cell: ____________________ Work:________________________

**Email Address:** ______________________________________________________________

**Marital Status:** ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widow

**Do you use tobacco?** Yes No

**Do you use recreational drugs?** Yes No

**Do you drink alcohol?** Yes No **If yes, how often?** ________________

**Are you pregnant?** Yes No

**Are you employed?** Yes No **Employer?** ______________________

**Occupation?** ______________________________________________________________

**Number of hours spent on your feet:** ____________ **Steel tipped boots?** Yes No

**Primary Care Physician:** ______________________________________________________

**Date you last saw your doctor:** _________________________________________________

**Endocrinologist:** ______________________________________________________________

**Cardiologist:** ______________________________________________________________

**Pharmacy** *(Name and City):* ______________________________________________________

**What is the reason for your visit today?**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Are you allergic or have you ever had a reaction to any of the following?**
*(Please circle all that apply)*

| | | |
|---|---|---|
| Anesthesia | Iodine | Penicillin |
| Aspirin | Latex | Radiographic Contrast/Dye |
| Band Aids/Tape | Lidocaine | Sulfa Drugs |
| Codeine | Novocaine | |

Other ______________________________________________________________________________

**Do you have or have YOU ever been treated for any of the following?**
*(Please circle all that apply)*

| | | |
|---|---|---|
| Amputation | Epilepsy | Lung Disease |
| Anemia | Gout | Neuropathy |
| Arthritis | Gerd | Osteoporosis |
| Asthma | Heart Attack | Psychiatric Disorder |
| Back Pain | Hepatitis | Seasonal Allergies |
| Blood Clot | High Cholesterol | Stomach Ulcer |
| Bunion | HIV/AIDS | Stroke |
| Cancer | Hypertension | Thyroid Disease |
| Circulation Problems | Kidney Problems | Ulcer/Wound |
| Type I Diabetes (Juvenile) | Liver Disease | Vision Problems |
| Type II Diabetes | Chronic Kidney Disease | Retinopathy |

**Do you have any FAMILY HISTORY (mom, dad, aunt, uncle) of any of the following?**
*(Please circle all that apply)*

| | | |
|---|---|---|
| Arthritis | Diabetes | Hypertension |
| Bleeding Disorders | Foot Deformities | Osteoporosis |
| Cancer | Heart Disease | Stroke |

**Do you use any of the following assistive devices?**

| | | |
|---|---|---|
| Walker | Cane | Crutches |
| Wheelchair | Braces | |

**Have you ever had foot surgery?** Yes No

If yes, please list type and date of surgery ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list all other surgeries and dates__________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Patient Initials______________

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**PRIMARY Insurance Name:** ______________________________________________

**Insured's Name:** ______________________________________________

**Insured's Date of Birth:** ____________________ **Social Security #:**____________________________________

**Relationship to patient:**______________________________________________

**SECONDARY Insurance Name:** ______________________________________________

**Insured's Name:** ______________________________________________

**Insured's Date of Birth:** ____________________ **Social Security #:** ____________________________________

**Relationship to patient:** ______________________________________________

**Assignment and Release**

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

| ______________________________ | ______________________________ | ______________________________ |
|---|---|---|
| Responsible Party | Relationship | Date |

**Medicare Authorization**

I request that payment of authorized Medicare benefits may be made to Bangor Podiatry LLC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on 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 physicians 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 non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

| ______________________________ | ______________________________ | ______________________________ |
|---|---|---|
| Responsible Party | Relationship | Date |

I acknowledge that I was provided a copy of the Bangor Podiatry LLC Notice of Privacy Practices. This notice describes how Bangor Podiatry LLC may use and disclose my protected health information, certain restrictions, on the use and disclosure of my healthcare information as well as the rights I may have regarding my protected health information.

| ______________________________ | ______________________________ | ______________________________ |
|---|---|---|
| Responsible Party | Relationship | Date |

Patient Initials ____________

BANGOR PODIATRY LLC

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*Simon G. Tabchi, DPM • Jason Eberly, DPM*

I authorize the doctors and staff of Bangor Podiatry LLC to discuss the details of my treatment/condition in person or by telephone with the following individuals only:

| Name | Phone | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

Patient/Guardian Signature: ____________________________________________ Date: ________________________

I give my permission for Bangor Podiatry LLC to leave a message of my answering machine regarding any medical related issues concerning my treatment by the doctors of Bangor Podiatry. Yes No

**Patient Medication List**

| Medication | Dosage | Frequency |
|---|---|---|
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Patient Initials ____________