HOWARD HOROWITZ, DPM BOWIE FOOT AND ANKLE
17000 Science Dr. Suite 104
Bowie, MD 20715
301-464-5900

BOWIE FOOT&ANKLE
Howard Horowitz, DPM

New Patient Information

Today's Date:_____

PATIENT INFO:

Name: _____ **Sex:** _____ **Date of Birth:** ___/ ___/ _____
(Last, First MI)

Address: _____
(street) *(City, state, zip)*

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **Email:**_____

Social Security. #_____ *(Required)* **Marital Status:** _____

Employment Status: _____ **Place of Employment:** _____
(Full time/part time/retired/unemployed)

****If Child, list parents' name:**
Father: _____ **Mother:** _____

RESPONSIBLE PARTY: *(If same as patient, just write "self")*

Name: _____ **Sex:** ___ **Home Phone:** _____
(Last, First MI)

Work Phone: _____

Address:_____

Cell Phone: _____

_____

Date of Birth: ___/ ___/ _____ **Email:** _____ **Relation:** _____

	PRIMARY INSURANCE	*SECONDARY INSURANCE*
Insurance Company		
Policy Holder		
Id Number		
Group Number		
Policy Holder DOB		
Policy Holder SSN		
Relationship to Policy Holder		

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FOOT HEALTH: Circle if you are now or have ever been treated for:

corns/calluses	*warts*	*athlete's feet*	*leg/foot ulcers*	*fungal nails*	*ingrown nails*
flat feet	*neuroma*	*foot numbness*	*broken bones*	*ankle sprain*	*rash*
bunions	*arch pain*	*hammertoes*	*knee pain*	*heel pain*	*high arch feet*
childhood foot problems	*lower back pain*	*gait(walking) problems*	*cramps in legs/feet*		

Are your first steps out of bed painful? YES NO Then subsides? YES NO

Do you get leg cramps during the day? YES NO At night? YES NO

Any pain in calves or buttocks when walking? YES NO Is it relieved by stopping & standing still? YES NO

List the sports/type of dance you are active in: _____

Your type of job activity/occupation: _____ Hours per day on feet: _____

Shoe Size: _____ Weight: _____ lbs. Height: _____ ft. _____in.

GENERAL HEALTH HISTORY: Circle: if you are now or have you ever been treated for:

Stroke	*Heart Attack*	*High Blood Pressure*	*Phlebitis*
Vascular Disease	*Heart Condition*	*Diabetes*	*Insulin yes/no*
Headache	*Hepatitis*	*Liver Disease*	*Anemia*
Sciatica	*Rheumatic Fever*	*Alzheimer's*	*Epilepsy*
Keloid/thick scar	*Nerve Disorder*	*Hearing/ear disorders*	*Glaucoma*
Psychiatric Disorder	*Kidney disease*	*Thyroid Problem*	*Asthma*
Lung Disease	*Tuberculosis*	*Stomach Ulcer*	*Cancer*
Osteoporosis	*Poor Circulation*	*Arthritis*	*Lyme's Disease*

Do you have joint implants? YES NO If yes, where? _____

Do you have a history of heart valve problems? YES NO

Drink alcoholic beverages? None rarely moderately daily quit

Use recreational drugs? None rarely moderately daily quit

Smoker? Former _____ Never _____ Current: Packs/day: _____ Years: _____

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List major surgeries: _____ **Date:**_____

_____ **Date:**_____

Other hospitalizations: _____ **Date:**_____

_____ **Date:**_____

Your preferred pharmacy: _____ **Phone:** _____

Address: _____
(street) *(City, State)*

Your General Physician: _____ **Phone:** _____

Street/City: _____
(Street) *(City, State)*

ALLERGIES: Are you allergic to any of the following? Please circle:

Penicillin	**Codeine**	**Demerol**	**Novocain**	**Aspirin**
Advil	**Aleve**	**Sulfa Drugs**	**Motrin**	**Adhesive Tape**

Please List any others: _____ _____

_____ _____

MEDICATIONS: Please list any medications you are currently taking:

**if additional space is needed please continue on back*

Medication/Dose:	***Reason for taking:***	***Frequency:***

How did you hear about our office/who should we thank for referring you to us?

__Doctor __Patient __Family __Friend __Phone Book __Other

Name/Source: _____

Today's Foot Complaint: _____ **Duration:**_____

2nd foot complaint: _____ **Duration:**_____

Dr. Notes: _____

_____

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INSURANCE AUTHORIZATION AND ASSIGNMENT

Please remember insurance is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, COPAY, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.** We request that these charges be paid at the conclusion of each visit. If it becomes necessary for this account to be turned over for collection, you will be responsible for all related costs as well as any balance due.

I hereby authorize any holder of medical and/or other information about me needed to determine benefits for related services to release such information to the Centers of Medicare & Medicaid Services or other insurance companies.

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Howard Horowitz, D.P.M. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance.

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 understood the Notice.

_____ _____

Patient Name (Print Please) Date

_____

Signature

if you would like a copy of HIPPA please ask the front desk