DAVID GITLIN, DPM FOOT & ANKLE SURGERY

New Patient Packet

PATIENT INFORMATION

***DATE*:** _____

First Name: _____ MI: _____ SSN#: _____ Gender: □ M □ F

Last Name: _____ DOB: _____/_____/_____ Age: _____

Address: _____ Marital Status: □ Married □ Single □ Divorced □ Widowed

City, State, Zip: _____ Race/Ethnicity: _____

Phone 1: _____ □ Home □ Work □ Mobile Primary Language: _____

Phone 2: _____ □ Home □ Work □ Mobile Email Address: _____

Phone 3: _____ □ Home □ Work □ Mobile Height: _____ Weight:: _____

Patient Employment Information

□ Employed □ Retired □ Student

Occupation: _____

Employer: _____

Phone: _____

Address: _____

City, State, Zip: _____

Primary Care Physician

Name: _____

Phone: _____

Address: _____

City, State, Zip: _____

**Who referred you to us? _____

Pharmacy Information

Primary Pharmacy: _____

Phone: _____

Address: _____

City, State, Zip: _____

Emergency Contact

Name: _____

Phone: _____

Address: _____

Relationship: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Carrier: _____

Insured ID: _____

Policy Group #: _____

Policy Holder: _____

□ Self □ Spouse □ Parent □ Partner

DOB: _____/_____/_____ SSN#: _____

Secondary Insurance

Insurance Carrier: _____

Insured ID: _____

Policy Group #: _____

Policy Holder: _____

□ Self □ Spouse □ Parent □ Partner

DOB: _____/_____/_____ SSN#: _____

** ***Please List who we can share your medical information with*** : _____

Did you sustain this injury at work? □ Yes □ No

(If no, you may skip this section. If yes, the information below is mandatory prior to seeing your doctor)

Worker's Compensation Information

Insurance Carrier: _____

Billing Address: _____

City, State, Zip: _____

Claim Number: _____

Employer (at time of injury): _____

Attorney (if applicable): _____

Date of Injury: _____

Body Part(s): _____

Claims Adjuster: _____

Adjuster Phone: _____

Adjuster Fax: _____

Location of Injury: City: _____ State: _____

Are your injuries car accident related? □ Yes □ No (If no, please continue with the rest of the packet. If yes, please inform the front desk)

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REASON For VISIT (and which foot is it) _____

Symptoms made worse by: _____

Symptoms made better by: _____

Treatment (prior to visit): _____

Has another physician treated you for this injury? □ Yes □ No

(If yes, please provide physician's name & phone):

Name: _____

Phone: _____

Personal Medical History: _____

Prior Surgeries (please list year, surgery, doctor): _____

Medications / Dosage (include over the counter and vitamins):

Allergies

PREGNANT □ Yes □ No **ORAL CONTRACEPTIVE** □ Yes □ No

Smoking History: □ Never □ Currently Smoke □ Quit Smoking

packs per day_____; if quit, when you last smoked? _____

Major Family Medical Conditions: _____

Alcohol Use: □ Never □ Rare □ Social □ Frequent

Recreational Drugs : _____

REVIEW OF SYSTEMS

Make check mark for all that apply

	Do you have this problem?	Do you receive treatment for it?	Does it limit your activities?
Heart Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
High Blood Pressure	□ No □ Yes	□ No □ Yes	□ No □ Yes
Lung Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Diabetes	□ No □ Yes	□ No □ Yes	□ controlled
Ulcer or Stomach Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Kidney Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Liver Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Anemia or other Blood Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Cancer	□ No □ Yes	□ No □ Yes	□ No □ Yes
Depression	□ No □ Yes	□ No □ Yes	□ No □ Yes
Osteoarthritis, Degenerative Arthritis	□ No □ Yes	□ No □ Yes	□ No □ Yes
Rheumatoid Arthritis	□ No □ Yes	□ No □ Yes	□ No □ Yes
Back Pain	□ No □ Yes	□ No □ Yes	□ No □ Yes
Thyroid Disorder	□ No □ Yes	□ No □ Yes	□ No □ Yes
Other:	□ No □ Yes	□ No □ Yes	□ No □ Yes

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Written Acknowledgement of Receipt of the Notice of Privacy Practices

Last Name	First Name	Date of Birth

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have any further questions or complaints, I may contact 239-465-0311.

I also understand that I am entitled to receive updates upon my request if the Limb Center Notice of Privacy Practices is amended or changed in a material way.

Assignment of Benefits

Your signature is required for us to process any insurance claims and to ensure payment of services is rendered.

I authorize the release of all medical information necessary to process my insurance claims or that is pertinent to medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This assignment will remain in effect until revoked by me in writing.

A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Consent for Treatment

I give full consent for treatment today and any subsequent visit treatment.

Out of Network Insurance Patients

I have been advised and understand that the office of Dr.Gitlin is **NOT DIRECTLY CONTRACTED** with my insurance provider. I have been advised of participation status.

Estimated charges for out of network service will be discussed before any service is provided, there will be no surprise bills.

Payment Policy

I clearly understand the above information and accept responsibility for my bill. Payment is due 30 days after receipt of bill. Patient or responsible party will be charged 9% per annum. If delinquent balance is not paid by final letter due date you may be forwarded to attorney/collection agency and you will be required to pay all collection fees and any related costs as well as interest aforesaid.

Signature Patient / Parent or Guardian	Date