



Medical, Surgical & Cosmetic Care  
For Your Foot And Ankle

410.426.5508

Fax:410.877.6979

1050 North Point Rd #200 | Baltimore, MD 21224

5508 Harford Road | Baltimore, MD 21214

**PLEASE PRINT CLEARLY**

NAME: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ SEX:  F  M

INSURANCE NAME: \_\_\_\_\_

MEMBER ID: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

SURGERIES:  None  Foot Surgery  Vascular Surgery  Heart Surgery  Other: \_\_\_\_\_

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Ankle pain	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Chills/Fever	<input type="checkbox"/> C.O.P.D.	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dry Skin
<input type="checkbox"/> Fainting	<input type="checkbox"/> Gout	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heel Pain
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High BP	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Nausea
<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Foot Wart	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer
<input type="checkbox"/> Seizures	<input type="checkbox"/> Athletes Foot	<input type="checkbox"/> Foot Ulcer	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> OTHER:			

**PLEASE LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER**

NONE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES to MEDICATION**

None  Aspirin  Iodine  Latex  Local Anaesthetic  Penicillin  Sulfa  Other \_\_\_\_\_

**SOCIAL HISTORY**

TOBACCO USE:  NEVER  FORMER  SOMETIMES  EVERYDAY # PACKS/DAY \_\_\_\_\_

ALCOHOL USE:  NEVER  FORMER  SOMETIMES  EVERYDAY

**FAMILY HISTORY (CIRCLE THE APPLICABLE LETTER - Brother / Sister / Mother / Father)**

Diabetes B / S / M / F  Cancer B / S / M / F  Heart Disease B / S / M / F

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

IF YOU ARE DIABETIC: LAST BLOOD SUGAR \_\_\_\_\_ LAST A1c \_\_\_\_\_ SHOE SIZE: \_\_\_\_\_



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### Consent for Assignments of Benefits

I hereby give consent to Dr. Jay Seidel, DPM, P.A. Inc. to apply for benefits from the insurance carrier(s), whose name I have provided, and further give consent that all payments be made directly to Dr. Jay Seidel, DPM, P.A. Inc. of the surgical and /or medical benefits, if any, otherwise payable to me for services rendered by Dr. Jay Seidel, DPM, P.A. Inc.

### Authorization to Jay Seidel, DPM, P.A. if Adverse Benefit Determination

I also authorize Dr. Jay Seidel, DPM, P.A. Inc. to act as my representative, should they need to contact my insurance company to appeal an adverse benefit determination.

### MEDICARE ONLY

I request that payment of Medicare benefits given consent to by me, be made on my behalf to Dr. Jay Seidel, DPM, P.A. Inc. for any services furnished to me by Dr. Jay Seidel, DPM, P.A. Inc. I consent to any holder of medical or other information about me to release to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or the benefits for related services. Federal Law requires that physicians collect the yearly deductible and 20% co-payments from the patient.

### Consent for Treatment and Release of Information

I hereby give consent to Dr. Jay Seidel, DPM, P.A. Inc. to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment. Further, I give consent to Dr. Jay Seidel, DPM, P.A. Inc. to disclose complete information concerning records regarding the illness or accident to any collateral source (in the case of Medicare, the Social Security Administration and the Centers for Medicare and Medicaid) that will pay part or all of said medical bills.

### Financial Agreement

I understand that all bills for the doctor's services are due from me when rendered, and I am completely responsible for these charges regardless of any third-party interest, payor or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Dr. Jay Seidel, DPM, P.A. reserves the right to pursue delinquent accounts via third-party collection agencies or attorneys. In the event the physician refers my bill for collections, I agree to pay an additional \$35.00 to cover the services of processor costs to said physician in addition to the amount owed for the services rendered.

### 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 so chose) and understand the Notice as required by the Federal Law. This Consent and Assignment of Benefits is valid for all episodes of care rendered by Dr. Jay Seidel, DPM, P.A.

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at [www.crisphealth.org](http://www.crisphealth.org). Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Signature of Patient (or guarantor, if minor): \_\_\_\_\_ Date \_\_\_\_\_