HAMILTON FOOT CARE
Medical, Surgical & Cosmetic Care
For Your Foot And Ankle

410.426.5508
Fax:410.877.6979
5508 Harford Road | Baltimore, MD 21214
1050 North Point Rd #200 | Baltimore, MD 21224
2208 Old Emmorton Road #101 | Belair, MD 21015

PLEASE PRINT CLEARLY. (This information will be used to contact you regarding appointments and other medical information)

NAME: _____ SOCIAL SECURITY #_____ DOB: _____/_____/_____ SEX: ☐F ☐M

HOME ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: _____ WORK PHONE: _____ CELL:(call/text)_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT: _____ PHONE : _____

HOW DID YOU HEAR ABOUT US: _____ EMPLOYER:_____

PRIMARY CARE DR :_____ PHONE #: _____ FAX #:_____

PHARMACY: _____ PHONE: _____

REASON FOR VISIT: _____

SURGERIES: ☐None ☐Foot Surgery ☐Vascular Surgery ☐Heart Surgery ☐Other:_____

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐Ankle pain	☐Anxiety	☐Back Pain	☐Chest Pain	☐Chills/Fever	☐C.O.P.D.	☐Diabetes
☐Dry Skin	☐Fainting	☐Gout	☐Heart Attack	☐Heartburn	☐Heel Pain	☐Hepatitis
☐High BP	☐Hip Pain	☐Nausea	☐Leg Cramps	☐Melanoma	☐Asthma	☐Liver Disease
☐Pacemaker	☐Psoriasis	☐Foot Wart	☐Shortness of Breath	☐Aids/HIV	☐Anemia	☐Cellulitis
☐Blood Clots	☐Arthritis	☐Stroke	☐High Cholesterol	☐Cancer	☐Seizures	☐Athletes Foot
☐Foot Ulcer	☐Kidney Disease	☐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 - **B**rother / **S**ister / **M**other / **F**ather)

☐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. of 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.

I hereby give my express consent to receive automated text and voice messages at the phone number(s) listed in my profile.

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. 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**_____