Resnikoff Podiatry and Foot Surgery Centers

DR ADAM F RESNIKOFF

481 3rd ave. NY NY 10016

(212) 679-3338

PATIENT NAME:______________________________ AGE:______ DATE of BIRTH:______________

ADDRESS:____________________________________ TELEPHONE# (home):____________

BUSINESS NAME: _______________________________ TELEPHONE# (work):____________

BUSINESS ADDRESS:____________________________ TELEPHONE# (mobile):____________

SOCIAL SECURITY NUMBER:____________________ EMAIL:_____________________________

REFERRED BY:____________________________ INSURANCE:_____________________________

name of insured_ _ _ _ _ _ _ _ _ _ _ _ _ _

date of birth_ _ _ _ _ _ _ _ relationship _ _ _

MEDICAL HISTORY:

ALLERGIES: penicillin, other_______________________________________

DIABETES: Yes or No-------- HIV: Yes or No-------- Hepatitis: Yes or No

HEART: ____________________ BLOOD PRESSURE: high / normal

ASTHMA: Yes or No------STOMACH ULCER: Yes or No------SMOKING: Yes or No

NUMBNESS / TINGLING:_______________________________________

ARTHRITIS:_______________________________________

KIDNEY:_______________________________________

CANCER / TUMOR:_______________________________________

OPERATIONS:_______________________________________

MEDICATIONS:_______________________________________

MAIN COMPLAINT:_______________________________________

||||||||||||||||||||||| Benefits:||||||||||||||||

spoke to:__________	Date:______	
	[IN]	[OUT]
(ded)		
(%)		
(copay)		
(orthotics)		
(moop)		
(precert)		
(limitations)		
(timely filing)		
(send to)		

||||||||||||||||||||||||||||||||||||||||||||||||

I ACKNOWLEDGE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENTS AND ANY BALANCES FOR SERVICES RENDERED.

X____Date:________________