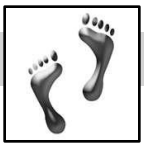
Maria A. Branca, DPM



Podiatrist

PATIENT INFORMATION

Last Name_____ First Name_____ MI_____ Soc. Sec. #_____ - _____ - _____

Address_____Apt_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ E-mail _____

Sex [ ] M [ ] F Age_____ Birth Date_____ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Patient's Employer _____Occupation_____

Business Address _____Business Phone_____

Notify in case of emergency_____ Relationship_____

Home Phone _____ Cell Phone _____ Work Phone _____

How did you hear about us? (Circle one) Google/Internet Physician Referral (who?)_____
Insurance Friend/Family Other_____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Member ID # _____ Group # _____

Subscriber's Last Name _____First Name_____ MI_____

Sex [ ] M [ ] F Relationship to Patient_____ DOB_____ Soc. Sec. #_____ - ____ - _____

Address (if different than Patient's) _____

Subscriber's Employer_____ Business Address_____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Member ID # _____ Group # _____

Subscriber's Last Name _____First Name_____ MI_____

Sex [ ] M [ ] F Relationship to Patient_____ DOB_____ Soc. Sec. #_____ - ____ - _____

Address (if different than Patient's) _____

Subscriber's Employer_____ Business Address_____

AUTHORIZATION

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date_____

I hereby authorize Dr. Branca to apply for benefits on my behalf for covered services rendered by her order. I request that payment from my insurance company be made directly to Dr. Branca (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature _____ Date_____

All Co-Pays and Payments are due in full at time of treatment, unless prior arrangements have been approved.

PLEASE COMPLETE BOTH SIDES

PODIATRIC AND HEALTH INFORMATION

Primary Care Physician _____ Phone _____

Address _____ Last Visit_____

What is the nature of your foot problem? _____

Height_____ Weight _____ Shoe Size _____

Are you in good general health? [ ] Y [ ] N If no, explain_____

Are your feet tired at the end of the day? [ ] Y [ ] N Have you had previous foot/ankle surgery? [ ] Y [ ] N

Have you ever broken a bone in your foot? [ ] Y [ ] N Do you smoke/use tobacco products? [ ] Y [ ] N

MEDICAL HISTORY

Check (✓) all that apply:

[ ] Arthritis, Rheumatism	[ ] Cramps/Numbness in feet or legs	[ ] Heart trouble	[ ] Liver trouble
[ ] Asthma	[ ] Diabetes	[ ] High Blood Pressure	[ ] Swelling of feet/ankles
[ ] Bleeding Disorder	[ ] Eye/Vision trouble	[ ] Kidney trouble	[ ] Varicose veins

Any Allergies or Sensitivity to:

[ ] Anesthetics	[ ] Foods	[ ] Novocain	[ ] Tapes
[ ] Drugs	[ ] Materials	[ ] Penicillin	[ ] Other

List any Prescription or Over-the-Counter Medications (and dosage) you are currently taking, if any:

_____ _____

_____ _____

_____ _____

List any Surgical History: _____

_____

_____

Family History:	**Father**	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
High Blood Pressure	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Epilepsy	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Eczema/Psoriasis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Attack/Stroke	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Hay Fever	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Credit Card on File Policy: (Optional) Your credit card information is kept confidential and secure and payments to your card are processed *only* after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorize Dr. Branca to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

[ ] Amex [ ] Visa [ ] MasterCard [ ] Discover

Credit Card Number: _____ **Expiration Date:** _____ **CVV Code:** _____

Cardholder Name: _____ **Cardholder Signature:** _____

Billing Address: _____

City: _____ State**:** _____ Zip **Code:** _____