Dr. Peter C. Hoffman, DPM,P.A.
9199 Reisterstown Road, Suite 107B
Owings Mills, Maryland 21117
Phone: 410-998-3993 Fax: 410-998-3995

Date:____________________

Patient's Name:_________________________ D.O.B. __/__/____ Age: _____ Sex: F/M

Address:_______________________ City: ___________ State:_____ Zip: ______

Home Phone: _____________ Work Phone: ____________ Cell Phone: ___________

Emergency Contact Name and Number: _______________________________________

PRIMARY CARE PHYSICIAN AND NUMBER: _________________________________

Social Security #:________________ Ethnicity(circle one): Hispanic/NonHispanic

Primary Insurance:____________________ Group Number: ______________
Insured Name: _______________________ D.O.B. (of insured): ___________
Relationship to patient:_________________

Secondary Insurance: __________________ Group Number: ______________

Third Insurance: _______________________ Group Number: ______________

Is the patient ambulatory? Yes or No (please circle one)
Home Settings: (please circle one) Group Home / Independent / College /
Home with Aid / Nursing Home

ALLERGIES:
Please circle if it applies to you:
ADHESIVE TAPE / ASPIRIN/ CODEINE / DEMEROL/ ERYTHROMYCIN/ LATEX
IODINE / LOCAL ANAETHETICS/ MORPHINE / PENICILLIN / SULFA / SEAFOOD
OTHER:____

HEIGHT: ____________ WEIGHT: ____________

Family History: Please circle which one has or had these.
Gout: M/F Diabetes: M/F Osteoporosis: M/F Osteoarthritis: M/F
Rheumatoid Arthritis: M/F

WHO REFERRED YOU TO OUR OFFICE: ______________________________

REASON FOR INITIAL VISIT:____

SURGICAL HISTORY: PLEASE CHECK IF YOU HAVE EVER HAD SURGERY IN YOUR LIFETIME

FOOT SURGERY_____ BY PASS SURGERY_____ CARDIAC_____ BACK SURGERY_____ GYN___ NEUROLOGICAL ___

JOINT REPLACEMENT___ VASCULAR SURGERY_____ OTHER________________________________

SOCIAL HISTORY (CHECK ONE)

TOBACCO: NEVER____ FORMER____ CURRENT___ //// DRUG USE: YES___ NO____

ALCOHOL USE: SOCIAL____ NONE____

PLEASE UNDERLINE IF YOU HAVE ANY OF THE COND. OR HAVE HAD THEM IN THE PAST

AIDS / ALZHEIMERS/ANEMIA/ASTHMA/BLOODCLOTS/DIABETES/COPD/CANCER/DEPRESSION

THYROID/GERD REFLUX/GOUT/ATHL. FOOT/CELLULITIS/HEPATITIS/HIGH BLOOD PRESSURE

HIGH CHOLES./KIDNEY DIS./LIVER DIS./OSTEOPOROSIS/HEART ATTACK/PHLEBITIS/ANXIETY/

PREGNANCY(NOW)/ RAYNAUDS/RHEUM.ARTH./SEIZURES/STOM.ULCER/OSTEOARTH/STROKE

REVIEW OF SYSTEMS **UNDERLINE IF THEY APPLY TO YOU PAST OR PRESENT**

CONSTITUTIONAL

WEIGHT GAIN / WEIGHT LOSS

CARDIOVASCULAR

CHEST PAIN/HEART PALP.

IRREGULAR HEARTBEAT

EMNT

EARS RING/DEAF/SINUS

DIFFICULTY HEARING

LYMPHATIC

ANKLE EDEMA(SWELLING)

MUSCULOSKETAL

HEEL PAIN/BACK PAIN

HIP PAIN/ LEG CRAMPS

INTEGUMENT

ECZEMA/PSORIASIS/DRY SKIN

ITCHING/ LEG ULCERS/WARTS

MELANOMA/NON HEALING WOUNDS

RESPIRATORY

SHORTNESS OF BREATH

GENITOURINARY

URINARY FREQ./URGENCY /INCONTINENCE

EYES

CATARACS/LEGALLY BLIND

BLURRED VISION

NEUROLOGICAL

NUMBNESS/ TINGLING

MEDICATION LIST

CHECK IF YOU BROUGHT A LIST WITH YOU: ____(WE WILL COPY IT)

MEDICATION REASON THE MEDICATION IS PRESCRIBED

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________

IF YOU ARE DIABETIC: LAST FASTING BLOOD SUGAR: ________

SHOE SIZE: ___________ A1C:__________________

DR. PETER C. HOFFMAN, P.A.
9199 REISTERSTOWN ROAD, SUITE 107B
OWINGS MILLS, MARYLAND 21117

CONSENT AND ASSIGNMENT

CONSENT FOR ASSIGNMENTS OF BENEFITS
I hereby give consent to Dr. Peter C. Hoffman, P.A. to apply benefits from the insurance carrier(s), whose name I have provided to Dr. Peter C. Hoffman, P.A. and further give consent that all payments be made directly to Dr. Peter C. Hoffman, P.A. of the surgical and /or medical benefits, if any, otherwise payable to me for services rendered by Dr. Peter C. Hoffman, P.A.

AUTHORIZATION TO DR. PETER C. HOFFMAN, P.A. IF ADVERSE BENEFIT DETERMINATION
I also authorize Dr. Peter C. Hoffman, P.A. 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. Peter C. Hoffman, P.A. for any services furnished to me by Dr. Peter C. Hoffman, P.A.. 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 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. Peter C. Hoffman, P.A. to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment of ________________________ (Patient). Further, I give consent to Dr. Peter C. Hoffman, P.A. to disclose complete information concerning records regarding the illness or accident of ________________________(Patient) 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. I authorize Dr. Peter C. Hoffman, P.A. to obtain my current medication list from Sure Scripts.

PRIVACY PRACTICE
I acknowledge that I have been told that a copy of the Notice of Privacy Practices (HIPPA) are posted at the front window in the office and understand the Notice as required by the Federal Law.

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

There are hundreds of different insurance policies and managed care options. Please appreciate the complexity of insurance coverage today. It is impossible to obtain payment for services without having the full cooperation of the patient. We are experts in foot care, but not insurance. We will help you if we can; however, it is ultimately your responsibility to know your insurance policy.

Does your insurance company require a referral from your primary care physician? Have you obtained that referral? The referral must be received by the time of your visit or you may be asked to pay for your visit. Many managed care plans do not issue referrals after the date of service. Look at your insurance card. If it does not state it, you may have to call them to inquire. The number is usually on the back of the card. Someone there should be able to answer your questions.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility, from the date of services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

IF UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE US 24 HOURS NOTICE. OTHERWISE WE RESERVE THE RIGHT TO CHARGE FOR TIME RESERVED.

Returned checks will be penalized to a $35.00 charge. We will then ask for a credit card number or a money order.

If you have any questions about the above information or any uncertainly regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help.

I hereby understand and I am responsible for giving this practice the correct insurance information.
I am also responsible for obtaining the proper referral or I will be responsible for paying the balance.
I have read, understand and agree to the above information.

Signature:____________________________________ Date:________________________