THE ADVANCED FOOTCARE CENTER
David P. Rosenzweig, DPM, PC
90 South Ridge Street, Suite LL-7
Rye Brook, New York 10573
Phone: 914.937.7077 / Fax: 914.937.7677

WELCOME TO OUR OFFICE

PLEASE PRINT ALL INFORMATION

Patient's Name: _____

Date of Birth: _____ Age: _____ SS#: _____ Gender: ○M ○F

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-Mail Address: _____

Occupation: _____

Preferred Language: _____

Preferred Pharmacy: _____

Name/Pharmacy # Address City/State

INSURANCE INFORMATION

Primary Medical Insurance: _____ ID#: _____ Group #: _____

Insured/Guarantor's Name: _____ Insured/Guarantor's SS#: _____

Insured/Guarantor's Date of Birth: _____

Insured/Guarantor's Address: _____

Insured/Guarantor's Phone: _____

Cell Home

Secondary Insurance: _____

Insured/Guarantor's Name: _____ Insured/Guarantor's SS#: _____

Insured/Guarantor's Date of Birth: _____

Insured/Guarantor's Address: _____

Insured/Guarantor's Phone: _____

Cell Home

How did you hear about us?

○ Referring Physician: (if any) _____ Phone: _____
Name

○ Referred by Patient/Family/Friend: _____
Name

○ Insurance Company ○ Internet search ○ Our Website ○ Other (please explain) _____

PATIENT'S OR GUARANTOR'S EMPLOYER

Employer: _____ Work Phone: _____

Address: _____

I request that payment of authorized Medicare or other insurance carrier benefits be made on my behalf to Dr. David P. Rosenzweig or The Advanced Footcare Center for any services furnished, and I authorized the release of medical information to insurance carriers for the purpose of processing claims. Furthermore, it is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility.

Signature: _____ Date: _____

MEDICAL HISTORY

NAME:_____
LAST FIRST MIDDLE

Have you been ill recently? Y / N

Have you been hospitalized in the last 3 years? Y / N

Are you under the care of a physician for any condition at this time? Y / N

Do you or have you ever had any of the following?

Diabetes	Y / N	Jaundice	Y / N
Rheumatic Fever	Y / N	Hepatitis	Y / N
Heart disease/attack	Y / N	Epilepsy	Y / N
High Blood Pressure	Y / N	Tuberculosis	Y / N
Anemia	Y / N	Asthma	Y / N
Stroke	Y / N	Venereal Disease	Y / N
HIV	Y / N	Are You a Smoker How much ?	Y / N _____

Are you taking any medicines or drugs now? Y / N

DRUG DOSAGE

1._____
2._____
3._____

Are you allergic to Penicillin? Y / N

-If yes, what reaction did you have?

_____

Are you allergic to any other medicines? Y / N

1._____
2._____

Do you have any circulatory problems? Y / N

-bleeding or clotting problems? Y / N

-sickle cell anemia? Y / N

Have you ever had surgery for a tumor or growth? Y / N

Are you pregnant? Y / N

Name and Address and phone number of your physician:

_____

_____
Signature of Patient Date