PATIENT INFORMATION

NO_____

DATE_____

NAME_____AGE_____SEX_____
LAST FIRST MIDDLE

BIRTHDATE_____SINGLE_____MARRIED_____ SOCIAL SECURITY_____

ADDRESS_____TOWN_____

STATE_____ZIP_____HOME PHONE #_____

CELL PHONE #_____

EMPLOYMENT_____WORK PHONE #_____
NAME

MEDICAL INSURANCE:_____
NAME ID #

SECONDARY INSURANCE:_____
NAME ID # CO-PAY

ARE YOU THE SUBSCRIBER? _____ IF NOT, PLEASE GIVE NAME and BIRTHDATE OF THE SUBSCRIBER:

_____
NAME DATE OF BIRTH

MEDICAL DOCTOR_____DATE LAST SEEN_____
FIRST LAST M / D / Y

_____
ADDRESS PHONE #

How did you hear about Dr. Riley?_____

ARE YOU A DIABETIC?_____MEDICATIONS FOR DIABETES?_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ?_____

Women: Are you pregnant?_____ Primary Foot Problem?_____

HMO PATIENTS: Having a referral does not necessarily mean your visit is a covered service. Some problems are not covered by your HMO INSURANCE COMPANY. IF YOU DO NOT HAVE A REFERRAL YOU WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES.

MEDICARE PATIENTS: Dr. Riley is a Medicare Participating Physician. We bill directly, and they pay us LESS any deductible or co-insurance (20% patient responsibility)

I AM AWARE THAT I AM FULLY RESPONSIBLE FOR ALL PAYMENT DUE TO DR. RILEY FOR HIS SERVICES. I authorize the release of any medical information necessary to process my claims.

Signature:_____

Date:_____

MD Referral_____ Letter sent_____

Signed Hippa form_____

Riley Podiatry Associates

MEDICAL INFORMATION

Reason for visit:_____

Approximate duration of symptoms: _____

List all past and current medical history/diagnoses:

_____

_____

List all current medications & dosages (including vitamins and supplements):

_____

_____

Please list all drug or food allergies and reaction:

_____

_____

Please list all surgeries that you have had and approximate year:

_____

_____

Please list all pertinent medical problems that run in your family:

_____

_____

Smoking/Tobacco Use:

☐ I do not use tobacco products
☐ I currently use tobacco products
☐ I quit using tobacco products in _____ (year)

Alcohol Use:
☐ None
☐ Occasional
☐ Quit drinking in _____ (year)

Women: Are you pregnant? _____ Yes _____ No