Cheralyn Perkins DPM **David Scalzo DPM ** Kathleen Hope DPM**Selina Kaminski DPM

Bangor Podiatry, LLC
129 N. 11th St
Bangor, PA 18013
Phone: 610-588-6621
Fax: 610-588-6307

Bangor Podiatry of Brodheadsville
1310 Route 209
Gilbert, PA 18331
Phone: 570-992-5779
Fax: 570-992-5806

Bangor Podiatry of Bethlehem
224 Nazareth Pike
Bethlehem, PA 18022
Phone: 610-588-6621
Fax: 610-588-6307

Date: _____

Name: _____
First, Middle, Last

Date of Birth: _____ Sex: M F

Race/ethnicity: _____ Language: _____

Height: _____ Weight: _____ Shoe Size: _____

Address: _____

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

Email Address: _____

Marital Status:	Married	Single	Separated	Divorced	Widowed
Do you use tobacco:		Yes	No		
Do you use recreational drugs?		Yes	No		
Do you drink		Yes	No	If yes, how often? _____	
Are you Pregnant?		Yes	No		
Are you employed?		Yes	No	Employer: _____	
Steel tipped boots?		Yes	No		

Occupation? _____ Number of hours on feet? _____

Primary Care Physician _____ Date last seen _____/_____/_____

Endocrinologist_____ Date last seen _____/_____/_____

Reason for today's visit:

_____

_____

Are you allergic to, or have you ever had a reaction to any of the following? (Please circle all that apply)

Anesthesia	Iodine	Penicillin
Aspirin	Latex	Radiographic Contrast/Dye
Band-Aids/tape	Lidocaine	Sulfa drugs
Codeine	Novocain	Other: _____

Do you have, or have you ever been treated for any of the following? (Please circle all that apply)

Amputation	Epilepsy	Lung disease
Anemia	Gout	Neuropathy
Arthritis	GERD	Osteoporosis
Asthma	Heart Attack	Psychiatric disorder
Back Pain	Hepatitis	Seasonal Allergies
Blood Clot	High Cholesterol	Stomach Ulcer
Bunion	HIV/AIDS	Stroke
Cancer	hypertension	Thyroid Disease
Circulation Problems	Kidney Problems	Ulcer/Wound
Type 1 Diabetes (juvenile)	Liver Disease	Vision Problems
Type II Diabetes	Dialysis	Retinopathy

Do you have any family history of any of the following? (please circle all that apply)

Arthritis	Mom	Dad	Brother	Sister
Bleeding disorder	Mom	Dad	Brother	Sister
Cancer	Mom	Dad	Brother	Sister
Diabetes	Mom	Dad	Brother	Sister
Foot Deformities	Mom	Dad	Brother	Sister
Heart Disease	Mom	Dad	Brother	Sister
Hypertension	Mom	Dad	Brother	Sister
Osteoporosis	Mom	Dad	Brother	Sister
Stroke	Mom	Dad	Brother	Sister

Do you use any assistive devices? (please circle all that apply)

Walker Wheelchair Crutches Braces Cane

Have you ever had foot surgery: Yes No

If yes, please list type and date of surgery

_____

_____

_____

Please list all other surgeries and dates

_____

_____

_____

_____

Primary Insurance Name_____

Insured's Name _____

Insured's Date of Birth _____ Relationship to Patient _____

Secondary Insurance Name _____

Insured's Name _____

Insured's Date of Birth _____ Relationship to Patient _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have/has insurance coverage and I assign directly to Bangor Podiatry LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Relationship Date

Medicare Authorization

I request that payment of authorized Medicare benefits may be made to Bangor Podiatry LLC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Insurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____ _____

Responsible Party Relationship Date

Privacy Practices

I acknowledge that I was provided a copy of the notice of privacy practices of Bangor Podiatry LLC. This notice describes how Bangor Podiatry LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, as well as the rights I may have regarding my protected health information.

_____ _____ _____

Responsible Party Relationship Date

I authorize the doctors and staff of Bangor Podiatry LLC to discuss the details of my treatment/condition in person or by telephone with the following individuals only:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient/Guardian Signature: _____ Date: _____

I gave my permission for Bangor Podiatry LLC to leave a message on my answering machine regarding any medical related issues concerning my treatment by the doctors of Bangor Podiatry.

YES NO

Patient Medication List

Medication	Dosage	Frequency

I _____authorize Dr. Cheralyn Perkins/Dr. David Scalzo/Dr. Kathleen Hope to electronically access my Insurance/Pharmacy in order to retrieve my current medications for my continuation of care.

Pharmacy Name	Pharmacy Address	Signature
_____	_____	_____