WELCOME TO OUR OFFICE

DARIN A. BOCIAN, DPM

CERTIFIED BY THE AMERICAN BOARD OF PODIATRIC SURGERY

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street or P.O. Box Apartmrnt # City State Zip

PERMANENT ADDRESS: _____
Street or P.O. Box City State Zip

PHONE : HOME # _____ CELL #: _____ WORK #: _____ STATUS: S M W D

SSN: _____ MALE _____ FEMALE _____ BIRTHDATE: _____ / _____ / _____

EMPLOYER: _____ PRIMARY PHYSICIAN: _____

INSURANCE INFORMATION

POLICYHOLDER NAME: _____ BIRTHDATE: _____ / _____ / _____

PRIMARY INSURANCE: _____CO-PAY $: _____

POLICY ID#: _____ GROUP #: _____

SUPPLEMENTAL INSURANCE: _____CO-PAY $: _____

POLICY ID#: _____ GROUP #: _____

PATIENT PRIVACY: Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy in the reception area. You are not required to read this notice; however, we would like your acknowledgment that you have been notified that the practice has such a Notice of Privacy Practices.

SIGNED: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

PRESENT COMPLAINT: _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

ARE YOU UNDER THE CARE OF A DOCTOR? NO _____ YES _____ IF YES, PLEASE STATE THE REASON:

_____

WHAT MEDICATIONS ARE YOU TAKING? _____

_____

DO YOU SMOKE? N Y # PACKS PER DAY: _____ PREVIOUSLY SMOKED? N Y # OF YEARS: _____

DO YOU DRINK ALCOHOL OR BEER? NO _____ YES _____ QUANTITY: _____

PLEASE CHECK THE APPROPRIATE BOXES. I HAVE OR HAVE HAD THE FOLLOWING:

☐ DIABETES ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ KIDNEY DISEASE _____

☐ LUNG DISEASE _____ ☐ LIVER DISEASE _____

☐ **I AM NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE**

I AM ALLERGIC TO:

☐ ASPIRIN ☐ IODINE ☐ NOVOCAINE ☐ ADHESIVE ☐ CODEINE ☐ PENICILLIN ☐ SULFA

☐ OTHER ALLERGIES: _____

By signing this form, I realize that I am giving Dr. Bocian permission to treat my condition in a manner that is reasonable and acceptable with todays medical standards. I understand I have the right to refuse treatment at any given time during the course of treatmentI hereby authorize release of information for insurance purposes. To the best of my knowledge, the above information is complete and accurate. I understand that Darin A. Bocian, DPM will make all efforts in collecting adequate reimbursement from my medical insurance. Any unpaid services such as office visits, annual deductibles, co-payments, insurance rejections, cash charges, etc. are my complete responsibility, and I will make payment to Darin A. Bocian, DPM in a timely manner.

SIGNED _____
(signature of patient or guardian)