E. Douglas Hutson, Jr., D.P.M.
2030 Center Street, Suite 101 • Northampton, PA 18067 • 610-261-1001
42 N. 3rd Street • Easton, PA 18042 • 610-253-4821

PATIENT INFORMATION

Date _____

Name _____ Sex M F Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security Number _____ Marital Status M S W D

E-mail address _____

Whom may we contact in case of emergency? _____

Emergency Contact Phone # _____ Relationship _____

May we speak to your spouse or adult child about your condition (or another person)? ❑ Yes ❑ No

Name of Person(s) _____ Phone _____

Are you diabetic? ❑ Yes ❑ No Family Doctor _____

Does someone have Power of Attorney for Healthcare for you? ❑ Yes ❑ No

If yes, person's name _____

Medication Allergies: _____

What Pharmacy do you use? _____

Location _____ Phone # _____

Patient Employer Information

Employer Name _____

Employer Address _____

Employer Phone Number _____ Occupation _____

Spouse's Information

Spouse's Name _____ Spouse's Date of Birth _____

Insurance Information

Name of PRIMARY Insurance _____ Co-pay $ _____

Address _____ Phone # _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Insurance ID # _____ Group # _____

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New Patient/History and Physical

Date: _____

Patient Name _____ DOB _____ ❑ BP_____ ❑ Height_____ ❑ Weight_____

Chief Complaint/Reason for this visit - _____

History of Present Illness: Location, Duration, Quality, Timing, Context, Severity, Modifying factors, Associated Signs/Symptoms

_____

_____

_____

_____

MEDICATIONS ❑ See med. sheet in chart

_____

_____

_____

_____

_____

_____

ALLERGIES ❑ NKDA

_____

_____

_____

_____

_____

_____

Past Medical History:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Surgical History:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History If unable to obtain from patient, state reason: ❑ aphasia ❑ dementia ❑ uncooperative

Check all that apply ❑ Patient unsure of history

Diabetes Type I	❑ Mother	❑ Father	❑ Sister	❑ Brother
Diabetes Type II	❑ Mother	❑ Father	❑ Sister	❑ Brother
Pre Diabetes	❑ Mother	❑ Father	❑ Sister	❑ Brother
Aneurysm	❑ Mother	❑ Father	❑ Sister	❑ Brother
Congenital Heart Disease	❑ Mother	❑ Father	❑ Sister	❑ Brother
Coronary Heart Disease	❑ Mother	❑ Father	❑ Sister	❑ Brother
High Blood Pressure	❑ Mother	❑ Father	❑ Sister	❑ Brother
Heart Attack	❑ Mother	❑ Father	❑ Sister	❑ Brother

Social History: If unable to obtain from patient, state reason: _____

Occupation: _____ Education Level _____

Tobacco use: ❑ No ❑ Yes, How much? _____ How long? _____

Alcohol use: ❑ No ❑ Yes, How much? _____ How long? _____

Other: _____

Name of SECONDARY Insurance _____ Copay $ _____

Address _____ Phone # _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Insurance ID # _____ Group ID # _____

RESPONSIBLE PARTY

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE

Name _____ Address _____

Phone # _____ Relationship to Patient _____

Employer Name and Address _____

Employer Phone Number _____

The signature below, authorized the release of any medical information necessary to process any claims submitted. I also request payment of benefits be made to Orowitz & Hutson Podiatry, PC, for any services rendered to me.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. This includes co-insurance, non-covered services, "less amounts that exceed maximum coverage", co-payments, deductibles, etc.

Payment for office visit(s) is due at the time of service, except for Medicare patients and for those insurances with which this office has a contractual agreement. **CO-PAYS ARE DUE AT TIME OF SERVICE.**

I authorize any holder of medical information about me to release to my current medical insurance company, including Centers of Medicare and Medicaid Services or its agents, any information needed to determine these benefits or the benefits payable for related services of the HIC/Policy Number written on this form. In addition, I request that payments of authorized Medicare or my insurance benefits be made/assigned on my behalf to Orowitz & Hutson Podiatry, PC.

For Medicare Patients Only – I request the payments of Medigap Benefits (secondary co-insurance) as noted on this form be made to Orowitz & Hutson Podiatry, PC, for any service rendered to me by Orowitz & Hutson Podiatry, PC.

I have read all of the information and I certify that this information is true and correct to the best of my knowledge. I will notify your office of any changes in the above information.

PATIENT SIGNATURE OR AUTHORIZED PERSON _____

Date _____ (Completion of the Form and Signature is Required)

I have reviewed my Patient Information Sheet and agree that there are no changes from the previous year.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

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INSURANCE SIGNATURE ON FILE/AUTHORIZATION FORM

(Benefit Assignment)

"I request that payment of authorized Medicare/Medigap/Insurance Benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents/my Medigap insurer/my insurance company any information needed to determine these benefits or the benefits payable for related services."

"I understand that I am financially responsible for any allowable amount not covered by my insurance carrier such as a deductible or coinsurance."

"I understand that in the event I have no insurance, I am financially responsible for payment of services by Orowitz & Hutson Podiatry, PC."

"I understand that, effective August 1, 2010, any collection charges and/or fees for delinquent accounts will be the responsibility of the patient/guarantor."

"I authorize electronic claim submission of my charge to the appropriate insurance carrier."

"I authorize my medical record reports to any facility deemed necessary in the care of my treatment."

"I have read, fully understand and agree to abide by the policies listed above."

(X)_____
(Patient Signature)

PATIENT COMMUNICATION FORM

I authorize Orowitz & Hutson Podiatry, PC and/or their staff to communicate medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Leave Appointment Message on:

❑ Answering Machine ❑ w/ Another Person
❑ Office Voice Mail ❑ Through Mail
❑ Via E-mail_____

Leave other Medical Information on:

❑ Answering Machine ❑ w/ Another Person
❑ Office Voice Mail ❑ Through Mail
❑ Via E-mail_____

List person(s) we are authorized to communicate with in regard to your medical information.

_____ _____

_____ _____

How often do you have someone (like a family member, friend or hospital worker) help you read hospital material?
❑ Never ❑ Sometimes ❑ Always

Race: *(please check all that apply)* ❑ Caucasian ❑ Hispanic ❑ African American ❑ Asian
❑ Other_____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Other _____

(X)_____
(Patient Signature)