COMPREHENSIVE PODIATRIC MEDICAL SERVICES, LTD.

NEW PATIENT INFORMATION

(We welcome you to our practice)

Name: Mr Mrs Ms Dr Last: _____ First:_____ MI:_____

Address: _____ Unit # _____ City _____ State _____ Zip _____

Telephone: Home: (_____)_____ Cell: (_____)_____ E-mail: _____

Date of Birth: _____ **Social Security No.:** _____ **Marital Status:** Single Married Divorced Widowed

Name of Employer: _____ **Occupation:** _____ **Work Tel:** (_____)_____

Employer Address: _____City _____ State_____ Zip _____

GUARDIAN INFORMATION

Who is Financially Responsible? _____ **Relation:** _____

Address: _____ City _____State _____Zip _____

Telephone: Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Date of Birth: _____ **Social Security No.:** _____

INSURANCE INFORMATION

(Please furnish us with your I.D. Card along with Primary and Secondary Insurance Cards for copies)

Carrier Name: _____ **Policy #:** _____ **Group #:** _____

Telephone: (_____)_____ **Name of Insured** _____ **Relation** _____

Employer of Insured: _____ **Telephone:** (_____)_____

Address: _____City _____State _____Zip _____

METHOD OF PAYMENT: Check _____ Cash _____

HEALTH INFORMATION

Who may we thank for your referral? _____

Reason for your visit? _____

Work Related? Y / N **Auto injury?** Y / N **Personal Injury?** Y / N **Date of the Injury:** _____

Have you ever been treated for this condition before? Y / N **If yes, by whom?** _____

Date of first treatment: _____ **Date of last treatment:** _____

Internist / Family Doctor: _____ **Telephone:** (_____)_____

Contact person in case of emergency: _____ **Telephone:** (_____)_____

Pharmacy Name / Address / Telephone: _____

FAMILY HISTORY: Mother: _____ Father: _____

ACTIVITY LEVEL: ATHLETIC MODERATE MILD SEDENTARY **HEIGHT:** ____'____" **WEIGHT:** _____lbs

TOBACCO - SMOKING: NEVER SMOKED FORMER SMOKER OCCASIONAL EVERYDAY _____packs/day

ALCOHOL - EtOH: DO NOT DRINK OCCASIONAL LESS than 1-2 DRINKS/DAY MORE than 1-2 DRINKS/DAY

IMMUNIZATIONS: CURRENT/UP-TO-DATE RECENTLY IMMUNIZED _____

CURRENT MEDICATIONS: _____

CURRENT MEDICAL CONDITIONS: _____

DRUG ALLERGIES: _____

PAST SURGERIES: _____

OTHER ALLERGIES: _____

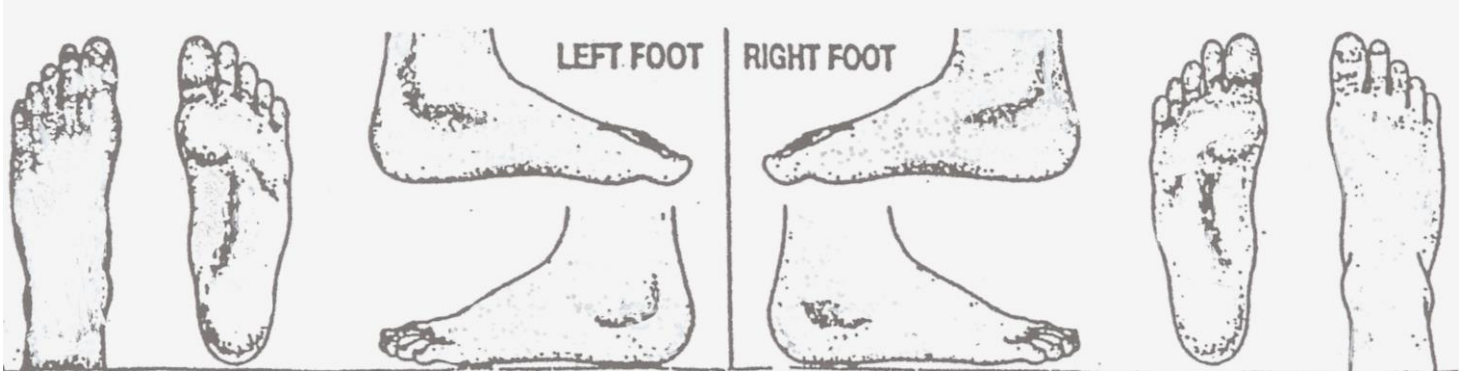
RECENT HOSPITALIZATIONS: _____

DO YOU HAVE:

Diabetes	Y / N	Joint Replacement Surgery	Y / N _____
Stomach / Duodenal Ulcers	Y / N	Arthritis / Rheumatism	Y / N
Clotting / Bleeding Problems	Y / N	Gout	Y / N
Blood Disorders / Anemia	Y / N	Osteoporosis	Y / N
HIV	Y / N	Poor Circulation / Phlebitis	Y / N
Hepatitis / Liver Disease	Y / N	Cancer	Y / N _____
Heart Condition / Disease	Y / N	Thyroid Problems	Y / N
Hypertension	Y / N	Cholesterol Problems	Y / N
History of Rheumatic Fever	Y / N	Glaucoma / Cataracts	Y / N _____
Chest Pains	Y / N	Stroke	Y / N
Shortness of Breath	Y / N	Epilepsy / Seizures	Y / N
Asthma / Lung Disease	Y / N	Nervous / Psychiatric Disease	Y / N
Kidney Disease / Infection	Y / N	Recent Blood Transfusions	Y / N _____

OTHER MEDICAL CONDITIONS NOT LISTED HERE: _____

LOCATION OF PAIN: (Please Circle)



AUTHORIZATION FOR TREATMENT AND BILLING
and
ACKNOWLEDGMENT OF RECEIPT OF JOINT
NOTICE OF PRIVACY PRACTICES

CONSENT TO TREAT

I seek care at Comprehensive Podiatric Medical Services, Ltd. voluntarily for the purpose of diagnosis, podiatric medical, and/or podiatric surgical treatment. I consent to and authorize the administration and performance of all tests, treatments, and procedures by the podiatric physicians on the podiatric medical staff and personnel at Comprehensive Podiatric Medical Services, Ltd. which, in the judgment of my podiatric physician may be considered necessary or advisable for the diagnosis and treatment of my condition while under his or her scope of care.

I understand that the practice of medicine and surgery is not an exact science and therefore acknowledge that no guarantees have been made to me as the result of treatment or examination by the podiatric physician. I understand that all medical treatment and diagnostic modalities can pose potential risks and side effects, and that, rarely, certain risks such as loss of limb and death, must be considered especially when contemplating surgical procedures under anesthesia.

I understand that if I decide to leave the care of my podiatric physician or decide not to follow his or her advice, I will assume all responsibility for any ill effects which may result from my action. I authorize the podiatric physician at Comprehensive Podiatric Medical Services, Ltd. to retain, preserve, send for pathologic examination, use for scientific, research, or educational purposes, or dispose of any tissue or specimen taken from my body unless otherwise requested in writing.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

In consideration of the medical and surgical services provided to me at Comprehensive Podiatric Medical Services, Ltd., I hereby assign to Comprehensive Podiatric Medical Services, Ltd., the podiatric physicians, and other professionals working under the direction of the podiatric physicians, all of my rights and claims for reimbursement under any Medicare, Medicaid, group accident, or any other health insurance policy for which benefits may be available for payment of services provided. I agree to pay the podiatric physicians at Comprehensive Podiatric Medical Services, Ltd. the balance due of all charges not paid for by the above-mentioned coverage including, but not limited to, deductibles, co-payments, and/or non-covered services (excluding those charges not collectable pursuant to Medicare regulations or third party contractual agreement). This may include the cost of collection and/or reasonable attorney fees.

Comprehensive Podiatric Medical Services, Ltd. may release information concerning my treatment to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid programs and its insurance carriers or intermediaries, to attempt to obtain reimbursement on my behalf for the treatment and services provided to me by its podiatric physicians. My authorization is not required for such release of information; however, the clinic will not release records regarding treatment for services requiring a restricted release under state or federal law without my authorization. If I wish to inspect or obtain a copy of my medical record (and for which I will be charged an additional fee), I may contact the medical records personnel at the clinic.

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and/or inspected the Joint Notice Privacy Practices of the podiatric physicians at Comprehensive Podiatric Medical Services, Ltd. I understand that the clinic and its physicians use the Joint Notice to comply with State and Federal privacy laws to provide a description of the uses and disclosures of my protected health information, and to inform me of my rights with respect to my health information, and with whom to file a complaint. I understand, acknowledge, and agree that the use of a Joint Notice, rather than the use of separate notices and forms from the clinic and its physicians, is for my convenience as a patient and to improve confidentiality.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE: _____

PRINTED NAME OF PATIENT: _____

DATE: _____