THOMAS RAMBACHER, DPM
PODIATRIC REGISTRATION AND HISTORY

Date: _____

Patient Name: _____
Address: _____
_____
City: State: Zip:

Sex: __M ___F Age: ____Birthdate: _____
Single____Married____Widowed____Seperated_____Divorced_____

Patient SS#:_____
Occupation:_____
Employer:_____
Employer Address: _____
Employer Phone:_____
Spouse's Name:_____
Birthdate: _____SS#:_____
Occupation: _____
Spouse's Employer: _____
Whom May we thank for referring you?
_____

Primary Care Physician: _____

PHONE NUMBERS

Home: _____ Cell:_____
Work: _____ Best time to reach you:___
In Case Of Emergency, Contact:
Name:_____Relationship: _____
Home: _____ Work: _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient: _____
Insurance Company: _____
Id #: _____
Is patient covered by additional insurance? Yes_____ NO_____
Subscriber Name: _____
Birthdate: _____ SS#:_____
Relationship to patient: _____
Insurance Co.:_____
ID #:_____

ASSIGNEMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr.Rambacher 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 the payment of benefits. I authorize the use of the signature on all insurance submissions.

Signature_____
Relationship: _____ Date: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Rambacher for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Heath Care Financing Administration and its agents any 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 non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:

PODIATRIC HISTORY

What is the chief complaint for which you need to be treated?
(Include foot, ankle, knee, hip, thigh complaints)
_____
_____

Have you ever been to a podiatrist before? _____YES _____NO
Name: _____
Last Visit: _____

Is there any personal or family history of diabetes? _____ YES _____NO
Cigarette or Tobacco use: _____
Years Smoked: _____

Athletic activities in which you participate:
_____
_____

Please indicate which foot problems you now have or have had in the past.
Ankle pain_____ Athlete's Foot_____
Bunions _____ Corns &Calluses_____

Cramps or Numbness in feet or legs_____
Flat feet_____ Foot or leg cramps_____
Heel Pain _____ Ingrown Toenails _____
Plantar's warts____ Tired Feet _____ Swelling___