Proactive Podiatry

Dr. Latika Hinduja
3578 Brodhead Rd. Monaca, Pa 15061
Phone: 724.775.6168 Fax: 724.775.2633

Today's Date: ____/____/____ Patient Chart Number: _____

Patient Name: _____ Age: _____

What is bringing you in to see the doctor today?_____

_____

General Health

Height: _____ Weight: _____lbs. Shoe Size: _____

Self	Family		Self	Family	
		Arthritis			Tuberculosis
		Mitral Valve Prolapse (Heart Murmur)			Cardiac Disease
		Scarlet Fever			Breathing Problems (explain: _____)
		Hypertension (High Blood Pressure)			Venereal Disease
		Peripheral Vascular Disease (Circulation)			Hemophilia (Bleeder)
		Gout			Stomach Problems
		Cerebral Accident (Stroke)			Renal/Kidney Disease
		Diabetes (Type: _____)			Polio
		Liver Disease			Cerebral Palsy
		HIV Positive (AIDS)			Muscular Dystrophy
		Blood Transfusion (when?_____)			Phlebitis/Thrombophlebitis (Clot)
		MRSA			Anemia (Blood Disorder)
		Thyroid Disease			Slow Healer
Other:					

Surgical History:
Please list ALL surgical intervention.

_____

_____

_____

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Personal History:

Tobacco Use: YES or NO	How often? Daily Socially Rarely	How Long? (years)
Alcohol Use: YES or NO	How often? Daily Socially Rarely	How Long? (years)
Recreational Drug Use: YES or NO	How often? Daily Socially Rarely	Name of Drug:

Are you taking any medications? YES or NO
If yes, please list below: (or provide us with a copy of list)
(Please include your prescription medication, vitamins, birth control pills, herbs, and any over the counter medications)

Allergies and Reactions:

Penicillin	Tetracycline	Aspirin	Foods (Please specify)	Adhesives
Sulfa Drugs	Novocain	Codeine	Caffeine	Other:
Barbiturates	Cortisone	Iodine Dyes	Enviromental (Please specify)	

Consent for Treatment

The above information is correct to the best of my knowledge and consent to such diagnosis procedures (including x-rays) and medical care and treatment as deemed necessary by Dr. Latika Hinduja.

Signature of Patient or Guardian:

_____ Date: _____

Signature of Witness:

_____ Date: _____

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Sex: MALE or FEMALE Birth Date: _____ Marital Status SINGLE MARRIED WIDOW DIVORCE

Social Security Number: _____-_____-_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

If the patient is a minor, please give the name of parent or guardian who is financially responsible for billing.

Name of spouse/parent: _____ Birth Date: _____

Spouse's/Parent's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone Number: _____ EXT: _____

Patient's occupation: _____

Patient's employer: _____

Employer's address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone Number: _____ EXT: _____

Other Information

Primary Care Physician (PCP): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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Have you ever received DME: YES or NO
(Walking Boot, Braces, Crutches, Cane, Walker, Shoes, and/or Orthotics)

Primary Pharmacy Name: _____

City: _____ State: _____ Zip Code: _____

In case of EMERGENCY contact

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Discussion of Medical Information

List any individuals with whom we may discuss your medical care and diagnosis. (Please provide **their** birthday for them to have access to any confidential information)

Name: _____ Relationship: _____

Phone Number: _____ Birth Date: _____

Name: _____ Relationship: _____

Phone Number: _____ Birth Date: _____

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Acknowledgement of Receipt of

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so choose) and understand the notice.

Assignment of Benefits

THE FOLLOWING IS REQUIRED BY LAW:
PLEASE READ CAREFULLY AND SIGN

I request and authorize **Dr. Latika Hinduja** to release any information to the Health Care Financing Administration, Medical Assistance and my insurance company required to process my healthcare claim for services rendered by **Dr. Latika Hinduja**. I understand my signature authorizes **Dr. Latika Hinduja** and staff to examine and treat me, including x-rays. I also understand payment for services or items could be for federal and/or state laws.

I hereby request payment be made directly to **Dr. Latika Hinduja**, by authorizing Medicare, Medical Assistance, and/or all other insurance companies for all services rendered to me through **Dr. Latika Hinduja**. I understand that I am personally responsible for all charges which Medicare, Medical Assistance, and/or any other insurance company may or may not pay, including but not limited to co-insurance, co-payments, deductibles, and non-covered services. I agree to make payment in full within 30 days of receipt of billing. Aged account balances may be forwarded for collection with additional fees being incurred. Finally, I understand and agree this authorization will remain in effect until the time I request, in writing, termination of this authorization.

NOTICE: If you receive podiatric care by another physician within the past 61 days, MEDICARE may not pay for these services, and you will be responsible.

NOTICE: Please be advised that it is your responsibility to ensure that Dr. Latika Hinduja is in your network prior to making an appointment.

Signature:	Date: