ANN M. HUDACEK, D.P.M.

Patient Name: _____ DOB: _____ Age: ____

Address: _____

Street City State Zip Code

Home Phone: _____ Cell: _____ Work: _____

E-Mail Address: _____

Gender: M/F SSN: _____ Married: Y/N Spouse's Name: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Emergency Contact _____ Phone: _____

Primary Care Physician: _____ Date last seen: _____

Referred by: _____

Ethnicity (circle one): Hispanic/Latino or Non-Hispanic/Non-Latino

Race (circle one): American Indian - Asian-Black/African American - Hawaiian/Pacific Islander White – Other

Preferred Language: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____ Relationship: Self/Spouse/Child

Subscriber's Employer: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____ Relationship: Self/Spouse/Child

Subscriber's Employer: _____

It is a requirement of our Insurance contracts to collect co-payments at the time of service. Physician and facility charges will be billed to you unless insurance information is provided to our office before the time of service. It is your responsibility to contact your insurance prior to services to determine if an authorization is required. Failure to obtain authorization will result in you being responsible for the services provided.

I consent to treatment for the care of the above patient. I authorize the release of all medical records to the referring and family physician and to the insurance carriers as needed to process a claim. I allow fax transmittal of medical records if necessary. I request insurance payments of medical benefits be made directly to the physician. I understand that I am financially responsible for all charges and that I will be expected to pay if my insurance has not paid within 90 days from the date of service.

Patient/Guarantor Signature: _____ **Date:** _____

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PATIENT QUESTIONNAIRE

(REQUIRED AT FIRST VISIT OR IF PATIENT HAS NOT BEEN SEEN FOR OVER 1 YEAR)

Patient Name: _____ Date: _____

Allergies: _____

Past Medical History: _____

Anxiety	Yes/No	Heart Disease	Yes/No
Arthritis	Yes/No	Hepatitis	Yes/No
Auto Immune Disease	Yes/No	High Blood Pressure	Yes/No
Bleeding Disorder	Yes/No	Kidney Problems	Yes/No
Cancer	Yes/No	Liver Disease	Yes/No
Chemical Dependency	Yes/No	Neuropathy	Yes/No
Circulatory Problems	Yes/No	Psychiatric Care	Yes/No
Depression	Yes/No	Respiratory Disease	Yes/No
Diabetes	Yes/No	Stroke	Yes/No
Gout	Yes/No	Ulcers	Yes/No
High Cholesterol	Yes/No		

Other: _____

Past Surgical History: _____

_____

_____

Tobacco Use: Yes/No

If yes, please check one: _____ Current every day _____ Current some days _____ Former

Alcohol Use: Yes/No

If yes, number of drinks per day: _____

Patient/Guarantor Signature: _____ **Date:** _____

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LIST OF MEDICATIONS

Patient Name: _____ Date: _____

Preferred Pharmacy & Location: _____

Allergies to Medications:

No ____ Yes ____ Please list: _____

NAME OF MEDICATION	DOSAGE (mg)	DIRECTIONS (times per day)