

# WELCOME

## TO OUR OFFICE

**DR. RICHARD I. LEBOVIC**  
Podiatric Medicine & Surgery

### PATIENT INFORMATION:

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_

Work / Cell Phone \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

Sex: M F Age \_\_\_\_\_ Marital Status: Single Married Widowed Separated

Name of Spouse (or Parents – if minor) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

### MEDICAL INFORMATION:

1. Are you currently under a physician's care? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

2. Are you a diabetic? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

3. Are you allergic to any medication? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

4. Have you been hospitalized in the past 5 years? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain \_\_\_\_\_

5. Are you subject to prolonged bleeding? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

6. Are you currently taking medications? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

Who may we thank for referring you to our office?

Yellow pages  Insurance G. Provider List  Advertisement

Doctor (Name: \_\_\_\_\_)  Patient (Name: \_\_\_\_\_)

Other \_\_\_\_\_

TODAY, I WILL PAY MY BILL BY:

\_\_\_\_ Cash \_\_\_\_ Check \_\_\_\_ Visa \_\_\_\_ MasterCard

DO YOU HAVE MEDICAL INSURANCE? \_\_\_\_ Yes \_\_\_\_ No

If yes, kindly present your card to receptionist and complete the other side of form

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Guardian, if minor)

Our entire staff is committed to providing you the finest podiatric care. Thank you for your trust.

## INSURANCE INFORMATION:

Primary Insurance Company \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's S.S. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employed by \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to Patient:    Self        Husband        Wife        Parent

Deductible: Individual \_\_\_\_\_ Family \_\_\_\_\_

Secondary Insurance (if any):

Name of Insurance Company \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's S.S. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employed by \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to Patient:    Self        Husband        Wife        Parent

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign all medical benefits, otherwise payable to me, to be paid directly to Dr. Richard Lebovic for services rendered. If my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct my/our insurance company to make out the check to me and mail as follows:

**c/o Dr. Richard Lebovic  
P.O. Box 6117  
East Brunswick, NJ 08816**

I understand that I am financially responsible for all charges whether or not paid by my insurance plan. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I/We agree that a photocopy of this Assignment shall be considered as effective as the original.

\_\_\_\_\_  
Signature of Patient/Insured/Guardian

Date: \_\_\_\_\_

## MEDICARE ONE TIME AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to Dr. Richard Lebovic for any services rendered on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or its agents any information needed to determine these benefits or the benefits payable for related service. 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 authorize the release 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 noncovered services**. Coinsurance and deductible(s) are based upon charge determination of the Medicare carrier. Once the physician has obtained the patient's one-time authorization, he may submit any later medicare claims, on either an assigned or non-assigned basis without obtaining any additional signature(s).

Signature \_\_\_\_\_

Date \_\_\_\_\_

# History and Physical

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart Number: \_\_\_\_\_

**Medical History:**

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues
<input type="checkbox"/> Liver	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Blood clot	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Diabetes (type I, type 2)	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> other (specify) _____	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Stroke	

**Are you pregnant?**  Yes  No    **Are you nursing?**  Yes  No

**Surgical History**  None  Appendectomy  C-Section  Angioplasty  Bypass  Cataracts  Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have any artificial joints?  Yes (where? \_\_\_\_\_)  No    Do you have an artificial heart valve?  Yes  No

**Social History**

Do you smoke?  Yes  No If yes how many packs per day?  1  2  3  4  5 For how long? \_\_\_\_\_

Do you drink alcohol?  Yes, everyday (5-7 days/week)  Yes, occasionally/socially  No/Rarely

Substance abuse:  Yes, I have a current substance abuse problem. Please specify: \_\_\_\_\_

Yes, I had a past substance abuse problem. Please specify: \_\_\_\_\_

No, I have never had a substance abuse problem

What is your occupation? \_\_\_\_\_ Does it involve mostly  standing or  sitting

Do you exercise regularly?  No, I do not exercise regularly  Yes, I do the following regular exercise: \_\_\_\_\_

**Family History** Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

**Review of Systems** (Please check the box if you currently have any of these symptoms or check "NONE")

<b>Cardiovascular</b>	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE
<b>Genitourinary</b>	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency	
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE
<b>Gastrointestinal</b>	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> constipation
<b>Integumentary</b>	<input type="checkbox"/> athlete's foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin
					<input type="checkbox"/> NONE
<b>Hematologic</b>	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders
					<input type="checkbox"/> NONE
<b>Neurological</b>	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE
<b>Musculoskeletal</b>	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis
					<input type="checkbox"/> NONE
<b>Respiratory</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE

**PLEASE READ AND SIGN**

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Practice:

Today's Date:

**Name:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Race:** \_\_\_\_\_  I prefer not to answer  I do not know  
 (White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

**Ethnicity:** \_\_\_\_\_  I prefer not to answer  I do not know

**Preferred Language:** \_\_\_\_\_  I prefer not to answer

**Pharmacy Name:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Address: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Address: \_\_\_\_\_

**Privacy Information Preferences**

Do you want to be exempt from public reporting?  Yes  No Can we send mail to the address on file?  Yes  No

Can we call the phone number on file?  Yes  No Can we leave voicemail on machine?  Yes  No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters?  Yes  No

If yes, please provide your e-mail address: \_\_\_\_\_

Who can we leave messages with?  Wife  Husband  Daughter  Son  Other: \_\_\_\_\_

Name(s): \_\_\_\_\_

**Smoking Status**

Current Every Day Smoker  Never Smoker

Current Some Day Smoker  I decline to answer

Former Smoker

**Vital Signs**

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Current Medications**

No Known Medications

I take the following prescriptions/over the counter medications:

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Name: \_\_\_\_\_ Dose \_\_\_\_\_

Use the back of this form if more room is needed

**Allergies**

Allergy	Reaction
<input type="checkbox"/> No Known Allergies	
<input type="checkbox"/> No Known Drug Allergies	
<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Shellfish	_____
<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Tape	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Betadine (iodine)	_____
<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Tylenol™	_____
<input type="checkbox"/> Ibuprofen	_____
<input type="checkbox"/> Codeine	_____
<input type="checkbox"/> Other (specify) _____	_____

**PLEASE READ AND SIGN:** The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_