Primary Care Physician

WM. J. WEISSINGER, DPM, DABPS
Foot Surgery
488 New York Avenue
Huntington, N.Y. 11743-3542

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Date _____ Cell# _____ Home Phone _____

Name _____ Soc. Sec. No. _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthday _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

ase of emergency who should we notify? _____

PRIMARY INSURANCE

.son Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. No. _____

Address (if different from patient) _____ Phone _____

City _____ State _____ zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract No. _____ Group No. _____ Subscriber No. _____

me of Other Dependents Covered Under this Plan _____

ADDITIONAL INSURANCE

atient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone _____

Insurance Company _____ Soc. Sec. No. _____

Contract No. _____ Group No. _____ Subscriber No. _____

Name of Other Dependents Covered Under this Plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company

and assign all insurance benefits to WILLIAM J. WEISSINGER D.P.M., DABPS
488 NEW YORK AVENUE
HUNTINGTON, NEW YORK 11743-3542 if any, otherwise payable to me for services rendered.

Understand that I am financially responsible for all charges whether or not paid by insurance . I hereby authorize the named doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

X _____ _____ _____
Responsible Party Signature Relationship Date

Wm. J. Weissinger, DPM

Medical History

Patient Name_____ **Date**_____

Who is your primary medical doctor ?_____

Are you seeing any other physician? For what?

Are you or have you been treated for any medical condition? (List)

List ALL surgeries you have had and dates:

Complications from Surgery?

List ALL medications, dosage, frequency that you are taking-(If you have a list we will copy it for you)

List ALL allergies-drugs/environmental/food

Have you had any podiatric treatment in the past? Please describe_____

Who referred you to the office?_____

William J. Weissinger, D.P.M., D.A.B.P.S.

Foot Surgery

488 NEW YORK AVENUE
HUNTINGTON, N.Y. 11743-3542
(631) 271-8500
FAX (631) 271-8555
E-mail: www.lifootsurgeon@yahoo.com

Date_____

I_____ am aware that if I am sent for any outside testing from Dr. Weissinger that I am to call this office to make a follow up appointment to go over any results after I have the testing done. I am aware that Dr. Weissinger **DOES NOT DISCUSS RESULTS OVER THE PHONE.**

X_____

William J. Weissinger, D.P.M., D.A.B.P.S.
Foot Surgery

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ACKNOWLEDGMENT 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 chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

X _____
Signature

Name_____ **DOB**_____ **Date:**_____

E-mail address: _____

Of the choices below, CIRCLE which best describes your Race:

American Indian/Alaskan Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White Other

Of the choices below, which best defines your Ethnicity:

( ) Hispanic/Latino ( ) Non-Hispanic/Latino ( ) Neither choice applies

Do you have any know <u>DRUG ALLERGIES?</u>

( ) No known drug allergies ( ) Ace Inhibitors ( ) Aspirin ( ) Codeine

( ) Erythromycins ( ) IVP Dye, Iodine Containing ( ) NSAIDS/Ibuprophen/Aleve

( ) Penicillins ( ) Sulfa Drugs ( ) Tetracyclines

Cigarette smoking History, please circle ANY that apply:

Current every day smoker Current some day smoker Former smoker

Never smoker

Please list the Name, Address, City , Zip code & Phone Number of the Pharmacy(s) you use:

1._____

2_____