

MARK A. LOMBARDO D.P.M., P.A.
PATIENT ACCOUNT INFORMATION (PLEASE PRINT)
FILL OUT COMPLETELY

DATE _____ PATIENT FIRST NAME _____ LAST _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # _____ WORK # _____ EXT# _____ CELL # _____

PATIENT'S S.S.# _____ MARRIED SINGLE OTHER BIRTH DATE _____

SEX _____ E-MAIL ADDRESS _____

REFERRED BY: FRIEND RELATIVE DR NAME _____

OCCUPATION _____ HOURS A DAY ON FEET _____ EMPLOYER _____

PRIMARY DOCTOR NAME _____ PHONE # _____

PHARMACY NAME _____ PHONE # _____

1ST INS NAME _____ ID # _____ GROUP # _____

POLICY HOLDER'S NAME _____ D.O.B. _____ S.S. # _____

RELATIONSHIP TO PATIENT _____

2ND INS NAME _____ ID # _____ GROUP # _____

POLICY HOLDER'S NAME _____ D.O.B. _____ S.S. # _____

RELATIONSHIP TO PATIENT _____

INSURANCE ASSIGNMENT, RELEASE AND AUTHORIZATION

I certify that I have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. Mark A. Lombardo, D.P.M. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to, **Mark A. Lombardo, D.P.M.** for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Guardian, or Personal Representative

Please print name of Patient, Guardian, or Personal Representative

Date

Relationship to Patient

**MARK A. LOMBARDO D.P.M. P.A.
PATIENT HISTORY (PLEASE PRINT)**

PATIENT NAME _____

DATE _____

PLEASE INDICATE WHICH PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST

DIABETES YES ___ NO ___
 HIGH BLOOD PRESSURE YES ___ NO ___
 GLAUCOMA YES ___ NO ___
 TUBERCULOSIS YES ___ NO ___
 RHEUMATIC FEVER YES ___ NO ___
 CANCER YES ___ NO ___
 VENEREAL DISEASE YES ___ NO ___
 HEPATITIS YES ___ NO ___
 HEART YES ___ NO ___
 KIDNEY YES ___ NO ___
 LIVER YES ___ NO ___
 LUNGS YES ___ NO ___
 STOMACH/INTESTINES YES ___ NO ___
 ARE YOU PREGNANT YES ___ NO ___

AIDS YES ___ NO ___
 ASTHMA YES ___ NO ___
 ARTHRITIS YES ___ NO ___
 NEUROLOGICAL YES ___ NO ___
 THYROID/GLANDULAR YES ___ NO ___
 URINE/LUNG INFECTION YES ___ NO ___
 DENTAL ABCESS YES ___ NO ___
 GOUT YES ___ NO ___
 BLEEDING DISORDER YES ___ NO ___
 PROSTATE YES ___ NO ___
 UTERUS/OVARIES YES ___ NO ___
 CIRCULATION/PHLEBITIS YES ___ NO ___
 OTHER _____
 LAST MENSTRUAL PERIOD ___/___/___

SURGICAL HISTORY:

LAST HOSPITALIZATION

___/___/___

CURRENT MEDICATIONS YOU ARE TAKING:

ARE YOU ALLERGIC TO ANY OF THESE:

ASPIRIN YES ___ NO ___
 PENICILLIN YES ___ NO ___
 NOVOCAINE YES ___ NO ___
 OTHER _____

CODEINE YES ___ NO ___
 IODINE YES ___ NO ___
 SULFA DRUGS YES ___ NO ___

FAMILY HISTORY: (MOTHER, FATHER, BROTHER, SISTER, GRANDPARENTS)

DIABETES _____
 HEART DISEASE _____
 CANCER _____
 TUBERCULOSIS _____
 GOUT _____
 HIGH BLOOD PRESSURE _____

PERSONAL HISTORY:

DO YOU SMOKE YES ___ NO ___
 PACKS PER DAY _____
 DRINK COFFEE OR TEA YES ___ NO ___
 NUMBER/CUPS _____
 DRINK WINE OR ALCOHOL YES ___ NO ___
 NUMBER /DAY _____
 DO YOU DO DRUGS YES ___ NO ___

SPECIFIC REASON FOR YOUR VISIT

ARE YOU HERE FOR A SECOND OPINION? _____ HAVE YOU SEEN ANOTHER PODIATRIST? _____
 IF SO, PLEASE LIST _____

PLEASE INDICATE WHICH FOOT PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST

ANKLE PAIN _____
 CORNS _____
 NUMBNESS _____
 INGROWN _____
 HEEL PAIN RT ___ LT ___ BOTH ___

ATHLETES FOOT _____
 CALLUSES _____
 FLAT FEET _____
 PLANTAR WART _____
 HAMMERTOES _____ FUNGUS _____
 OTHER _____

BUNIONS _____
 CRAMPS _____
 SWELLING _____
 ULCERS _____