THE ADVANCED FOOTCARE CENTER
David P. Rosenzweig, DPM, PC
90 South Ridge Street, Suite LL-7
Rye Brook, New York 10573
Phone: 914.937.7077 / Fax: 914.937.7677

WELCOME TO OUR OFFICE **PLEASE PRINT ALL INFORMATION**

Patient's Name: _____

Date of Birth: _____ Age: _____ SS#: _____ Gender: O M O F

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-Mail Address: _____

Occupation: _____

Preferred Language: _____

Preferred Pharmacy: _____
Name/Pharmacy # Address City/State

INSURANCE INFORMATION

Primary Medical Insurance: _____ ID#: _____ Group #: _____

Insured/Guarantor's Name: _____ Insured/Guarantor's SS#: _____

Insured/Guarantor's Date of Birth: _____

Insured/Guarantor's Address: _____

Insured/Guarantor's Phone: _____
Cell Home

Secondary Insurance: _____

Insured/Guarantor's Name: _____ Insured/Guarantor's SS#: _____

Insured/Guarantor's Date of Birth: _____

Insured/Guarantor's Address: _____

Insured/Guarantor's Phone: _____
Cell Home

How did you hear about us?

O Referring Physician: (if any) _____ Phone: _____
Name

O Referred by Patient/Family/Friend: _____
Name

O Insurance Company O Internet search O Our Website O Other (please explain) _____

PATIENT'S OR GUARANTOR'S EMPLOYER

Employer: _____ Work Phone: _____

Address: _____

I request that payment of authorized Medicare or other insurance carrier benefits be made on my behalf to Dr. David P. Rosenzweig or The Advanced Footcare Center for any services furnished, and I authorized the release of medical information to insurance carriers for the purpose of processing claims. Furthermore, it is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility.

Signature: _____ Date: _____

MEDICAL HISTORY

NAME:_____
LAST FIRST MIDDLE

Height_____ Weight_____ Blood Pressure_____

Have you been ill recently? Y / N

Have you been hospitalized in the last 3 years? Y / N

Are you under the care of a physician for any condition at this time? Y / N

Do you or have you ever had any of the following?

Diabetes	Y / N	Jaundice	Y / N
Rheumatic Fever	Y / N	Hepatitis	Y / N
Heart disease/attack	Y / N	Epilepsy	Y / N
High Blood Pressure	Y / N	Tuberculosis	Y / N
Anemia	Y / N	Asthma	Y / N
Stroke	Y / N	Venereal Disease	Y / N
HIV	Y / N	Are You a Smoker How much ?	Y/ N _____

Are you taking any medicines or drugs now? Y / N

DRUG	DOSAGE
1._____	
2._____	
3._____	

Are you allergic to Penicillin? Y / N

-If yes, what reaction did you have?

_____

Are you allergic to any other medicines? Y / N

1._____
2._____

Do you have any circulatory problems? Y / N

-bleeding or clotting problems? Y / N

-sickle cell anemia? Y / N

Have you ever had surgery for a tumor or growth? Y / N

Are you pregnant? Y / N

Name and Address and phone number of your physician:

_____

_____

Signature of Patient Date

The Advanced Footcare Center
Dr. David P. Rosenzweig, PC
90 South Ridge Street, Suite LL-7
Rye Brook, New York 10753
Phone: 914.937.7077 / Fax: 914.937.7677

PATIENT PRIVACY OBLIGATIONS THAT WE HAVE.

We are required by law to maintain the privacy of protected heath information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available here.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to:

David P. Rosenzweig, DPM
90 South Ridge Street, Suite LL-7
Rye Brook, New York 10573
914.937.7077

No retaliatory action will be taken against you for any complaint you may make.

I have received a paper copy of this notice.

_____
Signature

_____
Print Name

_____
Date

I make the following special request for confidential communications:

_____
_____
_____
_____
_____
_____

_____
Signature

_____
Date

THE ADVANCED FOOTCARE CENTER
90 South Ridge Street – Suite LL7
Rye Brook, New York 10573

ADVANCED NOTICE THAT YOUR INSURANCE COMPANY WILL NOT PAY FOR ALL SERVICES

Patient's Name	Date of Birth	Chart Number

Dear Patient:

- Your Insurance Company **does not pay** for all of your health care costs. Your Insurance only pays for covered benefits. Some items and services are not covered benefits and your insurance will not pay for them.
- When you receive an item or service that is **not a covered benefit, you are responsible to pay for the services.**

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision, you should read this entire notice carefully. **Ask us how much these items or services will cost you. Supplies or items dispensed to you in the office by the doctor or his staff are a chargeable item(s) and you will be required to pay for same.**

PATIENT'S AGREEMENT: I have been notified by my doctor that, my insurance is not likely to pay for the services identified. I agree to be personally and fully responsible for payment.

Signature of Patient:_____ **Date of Service:**_____

Provider Name:_____ **Address:**_____

AFC David P Rosenzweig, DPM, P.C.
The Advanced Footcare Center® Foot & Ankle Surgery • Laser Surgery • Sports Podiatry • Diplomate ABPS, FACFAS • Board Certified

CREDIT CARD INFORMATION:

Please be advised that effective January 1, 2022, with each transaction there will be a processing fee charged to your credit card.

Any open balance will be billed to your card. Your cooperation is appreciated. You May request a receipt.

Patients Signature_____Date_____

Please list card you will be using or allow us to copy it for future use:

VISA#_____Expiration Date_____Security #_____

Mastercard#_____Expiration Date_____Security #_____

American Express: _____Expiration Date_____Security #_____

Discover Card#_____Expiration Date_____Security #_____

Thank you for your cooperation:

The Advanced Foot Care Center

WWW.FootDoctorCenters.com
90 S. Ridge Street Rye Brook, NY 10573 • Tel (914) 937-7077 • Fax (914) 937-7677

NOTICE

Effective immediately

24 hours notice

must be given for cancellation and/or rescheduling of appointments.

If this procedure is not followed, there will be a **$75.00** missed appointment fee.

Thank you for your cooperation.

The Advanced Footcare Center

_____

Signature Date

Forms: notice
Missed appointment charges