DR. MAURICE LEVY ***Patient Information Form***

Name: _____

Address: _____

_____

SS# of Patient: _____

Primary Insurance: _____

Group#: _____

ID#: _____

Secondary Insurance Name:_____

Secondary Insurance ID#:_____

Date of Birth:
_____

Marital Status: M S W D

Telephone (H):
_____

Cell#: _____

Work#:
_____

Medicare#:
_____

Subscriber's Name:
_____

Subscriber's SS#:
_____

Secondary Group#:
_____

Chief Complaint:

Shoe Size:

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1. Do you have any general health problems and/or are you presently under a physician's care?
   Yes / No. If Yes, explain:_____
2. What medications are you currently taking, including non-prescription:_____

_____

3. Have you had any surgery in the past? If yes, explain:_____

_____

4. Any family history of Hypertension, heart disease, cancer, diabetes, or kidney disease? If so, please list:
   Condition: _____Relative: _____
5. Do you have any allergies? If yes, please list:_____

_____

6. Do you have or have you had any of the following? Please circle your answer.

Heart Ailment	Yes/No	Diabetes	Yes/No
High Blood Pressure	Yes/No	Hepatitis	Yes/No
Heart Murmur	Yes/No	Prolonged Bleeding	Yes/No
Renal/Kidney	Yes/No	Healing Complications	Yes/No
Epilepsy/Seizures	Yes/No	Immune System Disorder **(Thyroid, Lupus, Crohn's, HIV, etc)**	Yes/No
Cancer	Yes/No		
Do you smoke?	Yes/No	**If so, please specify:**_____	
Substance/Opoid Abuse?	Yes/No	Alcohol Consumption:_____	

Referred By: _____ Date: _____

Primary Physician: _____ Signature: _____

Maurice Levy, D.P.M.
Podiatric Medicine & Foot Surgery
Hartsville Professional Village
1210 Old York Road, Suite 103
Warminster, Pennsylvania 18974

Telephone: 215.675.1575
Fax: 215.682.7450

I certify that I have insurance coverage with_____, and assign directly to Dr. Levy all insurance benefits for services rendered. I understand that 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 understand that Dr. Levy may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print Name of Patient, Parent, Guardian or Representative Relationship to Patient

PRIVACY PRACTICES ACKNOWLEDGEMENT

To further protect your privacy we would like you to answer the following questions:

1. **Is it OK for our office to *leave a message* about your healthcare…**

   - **With a family member? YES NO N/A**
   - **On your home voicemail? YES NO N/A**
   - **On your cell phone? YES NO N/A**
   - **On your work voicemail? YES NO N/A**

2. **Is there anyone involved in your care that may pick up notes or any other correspondence on your behalf? List anyone who can act on your behalf in this capacity (spouse, family member, friend, caregiver, etc. _____**

   _____

   Please remember: You may request restrictions for making any contact by making the receptionist aware.

Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Patient Name:_____

Signature:_____

Date:_____ **Birthdate:_____**