Dr. Michael R. Pincus
DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY
CERTIFIED IN FOOT SURGERY

2207-A Golf Course Road SE
Rio Rancho, NM 87124-1954
(505) 896-1500

Please **PRINT** the following information
It is important to Our Records and Your Health

Name _____ Date of Birth _____ Age _____ Gender _____
Marital Status _____ Spouse _____ DOB _____
Street Address _____
City _____ State _____ Zip Code _____ Home Phone _____
Employed by _____ Business Phone _____
Primary Care Physician's Name _____ Telephone Number _____
Patient's Social Security Number _____ Medical or Surgical Insurance _____
Name of Responsible Party _____ Home Phone _____
Address _____
Employed by _____ Business Phone _____ ext. _____
Former Podiatrist _____ Approximate date of last visit _____
What is your present foot problem? _____
Emergency Contact _____ Phone _____ Relation _____
Who referred you to our office? _____

Race . . . . . ☐ Native American ☐ Caucasian ☐ East Indian ☐ Hispanic ☐ Asian ☐ African American ☐ Other
National Origin . . . . . ☐ Hispanic or Latino ☐ Other ☐ Not Hispanic or Latino
Primary Language . . . ☐ English ☐ Spanish ☐ Other

HEALTH INFORMATION

Please Answer Each Question

	YES	NO
1. Are you in good health?	☐	☐
2. Are you now or have you been under the care of a physician during the past two years?	☐	☐
3. Are you subject to nervous disorders, fainting or dizziness?	☐	☐
4. Are you subject to prolonged bleeding after tooth extraction or cuts?	☐	☐
5. Have you ever experienced any ill effects from Novocaine, Penicillin, or any other drugs?	☐	☐
6. Have you ever had any allergies? List	☐	☐
7. Are you taking any medicines or injections regularly? List	☐	☐
8. Have you ever had Cortisone Therapy?	☐	☐
9. (Females) Are you pregnant? What month?	☐	☐
10. Have you ever had any injuries or operations? List	☐	☐
11. Have you ever experienced unfavorable reaction from any previous Podiatric treatment?	☐	☐

PAST MEDICAL HISTORY

Have you ever been treated for any of the following

	YES	NO		YES	NO		YES	NO
diabetes	☐	☐	rheumatic fever	☐	☐	anemia	☐	☐
heart trouble	☐	☐	tuberculosis	☐	☐	arthritis	☐	☐
asthma	☐	☐	kidney ailment	☐	☐	varicose veins	☐	☐
high blood pressure	☐	☐	liver ailment	☐	☐	phlebitis	☐	☐
poor circulation	☐	☐	skin disorders	☐	☐	gout	☐	☐
hepatitis	☐	☐	HIV / AIDS	☐	☐	polio	☐	☐
alcoholism	☐	☐	epilepsy	☐	☐	seizures	☐	☐
arteriosclerosis	☐	☐	multiple sclerosis	☐	☐	stroke	☐	☐
cancer	☐	☐	pacemaker	☐	☐	thyroid disorder	☐	☐
emphysema	☐	☐	pneumonia	☐	☐	ulcers	☐	☐

REVIEW OF SYSTEMS

Check all that apply

Eyes	☐ blind spots ☐ double vision ☐ excessive tearing	☐ eye or vision problems ☐ loss of vision ☐ pain or soreness in eyes	☐ photo sensitivity ☐ other _____
Ears/Nose Mouth/Throat	☐ bleeding gums ☐ dental problems ☐ dentures ☐ difficulty with hearing	☐ difficulty with swallowing ☐ lost sense of smell ☐ post-nasal drip ☐ recent nose bleed	☐ ringing in ears ☐ sinus congestion ☐ sore throat ☐ other _____
Cardiovascular	☐ ankle swelling ☐ calf cramping ☐ cardiovascular problems ☐ chest pain	☐ fainting ☐ heart murmur ☐ pacemaker ☐ irregular heart beat	☐ phlebitis ☐ shortness of breath ☐ varicosities ☐ other _____
Respiratory	☐ COPD ☐ asthma ☐ breathing difficulties ☐ cough	☐ coughing up blood ☐ pain with deep breathing ☐ respiratory infections ☐ shortness of breath	☐ tuberculosis ☐ wheezing ☐ other _____
Gastrointestinal	☐ poor appetite ☐ abdominal pain ☐ blood in stool ☐ bowel habit change ☐ constipation	☐ excess gas ☐ heartburn ☐ hemorrhoids ☐ nausea ☐ rectal bleeding	☐ diarrhea ☐ vomiting ☐ yellowing of skin ☐ other _____
Genitourinary	☐ blood in urine ☐ currently pregnant ☐ kidney dialysis ☐ kidney stones	☐ lack of urine ☐ painful urination ☐ frequency ☐ frequent at night	☐ incontinence ☐ urinary infections ☐ prostate problems ☐ other _____
Musculoskeletal	☐ back pain ☐ heel pain ☐ hip pain ☐ joint pain ☐ joint redness	☐ joint swelling ☐ limitation of motion ☐ morning stiffness ☐ muscle cramps ☐ muscle tenderness	☐ muscular weakness ☐ joint tenderness ☐ stiffness ☐ other _____
Skin	☐ easy bruising ☐ eczema ☐ excessive scar tissue ☐ hair loss ☐ lower leg ulcers ☐ nail changes	☐ non-healing wound ☐ pigmentary changes ☐ psoriasis ☐ rash ☐ acne ☐ athlete's foot	☐ change in moles or new moles ☐ contact dermatitis ☐ dry, scaly skin ☐ other _____
Neurological	☐ convulsions ☐ difficulty with memory or speech ☐ headache ☐ neurologic symptoms or problems	☐ numbness ☐ paralysis ☐ poor coordination ☐ seizure	☐ tingling ☐ tremors ☐ uncontrolled movements ☐ other _____
Psychiatric	☐ anxiety ☐ depression ☐ emotional problems	☐ hallucinations ☐ nervousness ☐ previous psychiatric care	☐ trouble sleeping ☐ other _____
Endocrine	☐ cold intolerance ☐ diabetes ☐ heat intolerance	☐ increased water uptake ☐ thyroid replacement therapy ☐ unusual fatigue	☐ other _____
Hematologic and Lymphatic	☐ anemia ☐ bleeding tendency	☐ leg swelling ☐ lymph node enlargement	☐ previous transfusion ☐ other _____
Allergic/Immunologic	☐ reactions to drugs? specify _____ ☐ reaction to food? specify _____		

FAMILY HISTORY - Check all that apply

☐ atheriosclerosis	☐ heart attack	☐ migraine
☐ cancer	☐ hypertension	☐ osteoarthritis
☐ cardiovascular disease	☐ kidney disorders	☐ rheumatoid arthritis
☐ diabetes	☐ melanoma	☐ stroke
☐ emphysema		

SOCIAL HISTORY - Check all that apply

do you smoke? yes ☐ no ☐ How many cigarettes / day? _____

do you drink alcohol? yes ☐ no ☐ How many drinks / day or week? _____

Is there any other information about your health which should be known? _____

_____

Date _____ Signature _____

Michael R. Pincus, D.P.M., L.L.C.

Patient Name:_____
Date of Birth:_____

Preferred Pharmacy:
Pharmacy Name_____
Address_____
Zip Code_____ Telephone Number_____

[redacted]

Assignment, Release and Acknowledgement:

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of benefits including government benefits to Dr. Michael R. Pincus, (Michael R. Pincus, D.P.M., Michael R. Pincus D.P.M., L.L.C.). I, the undersigned certify that I have insurance coverage with the presented insurance company and assign directly to Dr. Michael R. Pincus, (Michael R. Pincus, D.P.M., Michael R. Pincus D.P.M., L.L.C.), all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize payment of benefits to be made to the physician rendering services. I also understand that I will be held responsible for any costs, which are not covered by my insurance carrier, including any deductible, co-insurance, co-pay, denial or any uncovered services. I understand that if Dr. Michael R. Pincus (Michael R. Pincus, D.P.M., Michael R. Pincus D.P.M., L.L.C.) does not participate with my insurance, I will pay for services rendered in full. I understand fully that is my responsibility to sign over all payments, including the Explanation of Benefits (EOB), to the examining provider. I hereby authorize Dr. Michael R. Pincus, Dr. Michael R. Pincus (Michael R. Pincus, D.P.M., Michael R. Pincus D.P.M., L.L.C.), to release all the information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am fully responsible for all fees incurred for services rendered including collection agencies. I also understand if I do not have insurance coverage all fees incurred for service rendered are due at the time of service. I understand the payment policies as outlined above.

_____ _____
Patient/Responsible Party Signature Date

Medicare Authorization:

I request that payment of authorized Medicare benefits be made to Dr. Michael R. Pincus (Michael R. Pincus, D.P.M., Michael R. Pincus D.P.M., L.L.C.), for any services furnished to me by Dr. Michael R. Pincus (Michael R. Pincus, D.P.M., Michael R. Pincus D.P.M., L.L.C.).
I authorize the release of information about me or any information needed to determine benefits or the benefits payable for related services to the Health Care Financing Administration and its agents. I understand my signature request that payment be made and authorized release of medical information necessary to pay the claim. If another health insurance is indicated, or electronically submits claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cased, 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 non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Patient/Responsible Party Signature Date