

GREGORY B. MORRIS, DPM, LLC

FOR OFFICE USE ONLY			
Account No	Type	Dr. #	Date

LAST NAME		FIRST NAME		MIDDLE NAME
SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS <input type="checkbox"/> Divorced	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
PATIENT'S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)				HOME PHONE
GUARANTOR'S NAME & ADDRESS, IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)				CELL/PAGER
EMPLOYER NAME/ADDRESS				BUSINESS PHONE
SPOUSE'S NAME		SPOUSE'S EMPLOYER		BUSINESS PHONE
EMERGENCY CONTACT NAME/ADDRESS (someone not living with you)				PHONE
REFERRING DOCTOR / PRIMARY CARE DOCTOR		ADDRESS		PHONE NUMBER
ETHNICITY (OPTIONAL)	PREFERRED LANGUAGE (OPTIONAL)	EMAIL ADDRESS		

If patient is a CHILD, please complete the following.

PARENT/GUARDIAN'S NAME		RELATIONSHIP TO PT	MARITAL STATUS <input type="checkbox"/> Divorced	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
HOME PHONE	BUSINESS PHONE	CELL/PAGER	CHILD'S SCHOOL	
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD			RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION

PRIVATE INSURANCE WORKERS' COMPENSATION NO-FAULT TPL

PRIMARY INSURANCE NAME & ADDRESS Phone: _____ Fax: _____	SUBSCRIBER NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
	MEMBERSHIP# / POLICY# / CLAIM #		GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS Phone: _____ Fax: _____	SUBSCRIBER NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
	MEMBERSHIP# / POLICY# / CLAIM #		GROUP #	COVG CODE
TERTIARY INSURANCE NAME & ADDRESS Phone: _____ Fax: _____	SUBSCRIBER NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
	MEMBERSHIP# / POLICY# / CLAIM #		GROUP #	COVG CODE

INJURY INFORMATION

DATE OF INJURY/ONSET	CONDITION(S) WE ARE TREATING YOU FOR TODAY
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FOR OFFICE USE ONLY:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:

I authorize Gregory B. Morris, DPM, LLC, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by said insurance.

These include deductible, co-payment, cost-share, and/or non-covered benefits. I also agree to pay a late payment fee of 1% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay a \$10.00 processing fee for each returned check.

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature

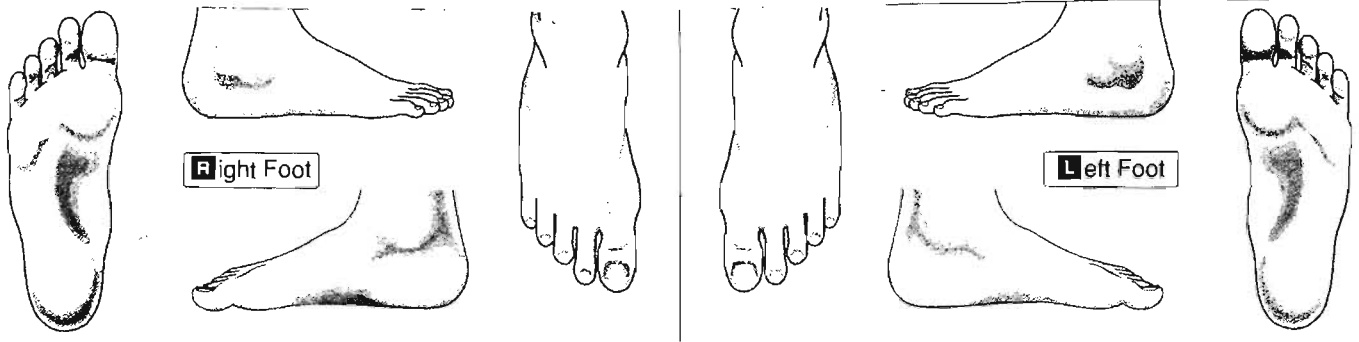
Relationship to Patient

Date

Rev 6/11

Patient's Name: _____ Date: _____

Please indicate on the diagram and in a few brief words, what is your foot or ankle problem?



When did this problem begin and what treatment has been done for it?

Do you have diabetes? YES NO

If Yes, when did you last see your physician? _____

Was this injury a Workman's Compensation or Auto Accident? YES NO

If Yes, Date of Injury: _____ Claim # (If Known): _____

Liability Insurance Company/Adjuster: _____

Address: _____

MEDICARE PATIENTS ONLY, PLEASE READ AND SIGN BELOW

Dear Patient:

Medicare regulations suggest that I, Dr Gregory Morris, inform you in advance, that some medical services may not be fully covered or reimbursed by Medicare. If in my professional opinion and judgment, the following services are needed in order to provide to you with the highest quality of care, they may not be completely reimbursed by Medicare:

Routine foot care and medical appliances.

Medicare may not reimburse these services for the following reasons: **Non-covered service.**

Gregory Morris, DPM, AACFAS _____ Date

Medicare Patient's Signature _____ Date

GREORY MORRIS, DPM, FACFAS AND PARTNER LINDA HO, DPM

MEDICAL HISTORY AND PATIENT QUESTIONNAIRE SHEET

PLEASE FILL OUT THIS SECTION AS COMPLETELY AS YOU CAN

FAMILY PHYSICIAN NAME: _____ DATE LAST SEEN: _____

PLEASE CIRCLE ANY ILLNESSES OR CONDITIONS YOU HAVE:

ARTHRITIS ASTHMA DIABETES/TYPE___ HOW LONG___ CANCER GOUT
HEART/PROBLEMS HEPATITIS/TYPE___ HIGH BLOOD PRESSURE HIGH CHOLESTEROL
KIDNEY PROBLEMS POOR CIRCULATIONS PROLONGED BLEEDING STOMACH ULCERS
STROKE LIVER/JAUNDICE TUBERCULOSIS OTHER: _____

FAMILY HISTORY: MOTHER: _____

FATHER: _____

SIBLING: _____

DO YOU CURRENTLY SMOKE? [] YES [] NO IF YES, AMOUNT PER DAY? _____ QUIT DATE _____

PLEASE LIST ALL YOUR MEDICATIONS:

DO YOU HAVE ANY ALLERGIES? PENCILLIN SULFA-DRUGS OTHER ANTIBIOTICS CORTISONE

SEAFOOD/COCAINE LIDOCAIN/LOCAL ANESTHESIA BETADINE/IODINE SHELLFISH FOOD

OTHERS: _____

PREVIOUS SURGERY :

I understand that my signature is on file authorizing release of my medical records or any other information required to process insurance forms. I also request payment of medical benefits to Gregory Morris, DPM and Linda Ho, DPM. I give my permission to said physicians to administer treatment and to perform such procedures as may be deemed necessary to the diagnosis and/or treatment of my foot and/or ankle conditions.

Signature of Patient/Parent/Guardian: _____

Date: _____

**GREGORY MORRIS, DPM, FACFAS
LINDA HO, DPM**

PODIATRY - FOOT & ANKLE SURGERY

QUEEN'S POB II #802

PHONE: 532-3338

MARY SAVIO BLD#122

Gregory B. Morris, DPM, FACFAS, LLC is in the process of implementing ePrescribing in our office.

ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information – like drug interactions and your prescription history.

The benefit to you:

- *Less confusion over handwritten prescriptions or unclear phone calls
- *Reduced possibility of medical errors
- *Less chance of adverse drug reactions
- *Fewer trips to drop off at the pharmacy
- *A safer, faster, easier way to get your prescription filled

Patient Consent

I agree that Gregory B. Morris, DPM, FACFAS, LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

EMAIL: _____

Signature of Patient: _____

Date: _____

Pharmacy of Choice:

Name: _____

Location: _____

**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
FOR**

GREGORY B. MORRIS, DPM, LLC

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Gregory B. Morris, DPM, LLC a copy of the Notice.

PRINT: _____

SIGN: _____

DATE: _____