Dr. John Cappa, D.P.M., F.A.C.F.A.S.

Date: _____
Patient Name: _____ **Date of Birth:** _____ **Sex**: ____M____F
Social Security #:_____ Employed: ___ Y___N **Occupation**: _____
Address: _____
(Street & Apartment) (City) (State) (Zip)
Home#: _____ **Work#**:_____**Cell#:** _____
Married Single Divorced Widowed

Primary Physicians Name/ Phone #: _____
Pharmacy_____Phone_____
How did you hear about us?
Doctor_____ Patient (Former/Current) _____

Insurance Information
Primary Insurance Name: _____
Policy Holders Name: _____ Social Security #: _____
Policy Holders Date of Birth: _____Patients Relationship to Policy Holder: _____

Reason for your visit: _____
Is this a Worker's Comp Case? YES or NO Is this visit related to a car accident? YES or NO

Shoe Size: _____ **Height**: _____ **Weight**: _____

Last Eye Exam: ____/___/____
Smoker: Yes No Previous smoker: Yes No Excessive Alcohol Yes No
Flu Shot: Yes No Date: ____/_____/_____ Pneumonia Shot: Yes or No Date: _____/____/_____
Diabetic: Yes No Date of Last A1C:_____/_____/_____
If diabetic, who handles your diabetes? _____ Phone #:_____

Medications: List current medications & dosage

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies: Yes No If yes, please list_____
Other Allergies including food: _____
Hospitalizations/Surgeries: List all surgeries you have had. Begin with the most recent. Give month and year_____
_____

Past Medical History: If you now have or have ever had any of the following conditions, please circle and be more specific in the blank space below:

Diabetes Type I or Type II	ADD/ADHD	Asthma
High Cholesterol	Heart Burn/Reflux	Gout
High Blood Pressure	Lymphedema	Prostate Problems
Thyroid (Low/ High)	Anxiety	Breathing Problems
Hepatitis_____	Bipolar Disorder	Current Kidney Dialysis
Cancer_____	Back Problems	Osteoarthritis
Ear Disorders _____	Alcohol/Drug Dependency	Lupus
Multiple Sclerosis	Anemia	Pre Diabetes
Hearing Loss	Currently Pregnant	HIV/AIDS
Circulation Problems	Depression	Osteoporosis/bone density
Eye Disorders _____	Children/Pregnancies	Kidney Problems_____
Heart Disease	Fibromyalgia	Neuropathy

Other_____

Family History: Please circle any medical conditions that run in your family and write which member(s) affected

Diabetes_____	Circulation Problems_____
Gout _____	High Blood Pressure_____
Heart Disease_____	High Cholesterol_____

Other_____

ASSIGNMENT OF BENEFITS:

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS A CLAIM TO MY INSURANCE COMPANY. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR. CAPPA FOR SERVICES RENDERED. I HAVE PROVIDED THE NECESSARY INFORMATION REQUIRED IN SUBMITTING A CLAIM, HOWEVER, I AGREE TO PAY FOR ANY SERVICES RENDERED OR REMAINING BALANCES NOT PAID BY MY INSURANCE COMPANY.

SIGNATURE _____

I ACKNOWLEDGE THAT I WAS GIVEN THE OPPORTUNITY TO READ AND/OR RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES AND HAVE UNDERSTOOD THIS NOTICE.

PARENT/AUTHORIZED REPRESENTATIVE _____

SIGNATURE _____

MEDICARE PATIENTS ONLY:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. JOHN CAPPA FOR SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE_____