Patient Registration Form

Dr. Andrea Cunha, DPM
Podiatric Medicine and Surgery
*Please note questions required by the Health Care Act

Name: First_____ Mid _____ Last _____ **Sex:** Male / Female

Date of Birth: _____ **SS#:** _____

Home Phone: _____ **Mobile Phone**: _____ **Work Phone**: _____

Email: _____ **Do you check or use your email daily:** Y / N

Preferred Method of Contact: (circle) Mobile Home Work Email

Street Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Occupation:_____

Height: _____ **Weight:** _____

Primry Health Insurance:_____**Policy #**_____

Secondary Health Insurance:_____**Policy #:**_____

Major Events/Past Surgeries:

_____

_____

Ongoing Medical Problems: (circle all that apply)

Hypertension Heart disease Skin disease Diabetes Asthma Auto immune disease

Cancer (please specify)_____ Other: _____

List of Medications: (currently taking)

_____

_____

Allergies: (medication/tape/food/dye/betadine,etc.)

_____

Smoker: Y / N **Former Smoker:** Y / N

Family Medical History: (Circle: Mother, Father, Sibling, Child, Relative)
Circle all that apply:
Hypertension Heart disease Skin disease Cancer (please specify) Diabetes Asthma
Auto-immune disease Other: _____

What is your complaint today?

_____

_____

Who may we thank for referring you?

_____

Primary Care Doctor: _____
Name of Practice: _____
Phone: _____

Pharmacy Affiliated With:

_____
Address: _____

*This information is taken in an effort for our practice to meet new healthcare requirements for compliance. You are entitled to review your health care record on line. If you have provided us with an mail address an access code will be sent to you from our electronic health records (EHR) Practice Fusion.

Signature:_____Date:_____

***PLEASE TAKE A MOMENT TO LIKE AND SHARE OUR PAGE ON FACEBOOK**

DR. ANDREA CUNHA-LOUGHMAN

INSURANCE AUTHORIZATION AND ASSIGNMENT FORM

I hereby authorize **Dr. Andrea Cunha** to diagnose, treat and manage the medical condition(s) presented at the time of the visit and to furnish all information to the insurance carriers concerning my illness and treatments. I hereby assign all insurance payments to **Dr. Andrea Cunha** for the medical services rendered to my dependants or myself. I understand that I am responsible by any amount that is not a covered service under my insurance.

All professional services rendered are submitted directly to your insurance company for payment, as long as we participate with the insurance company. If we do not accept your insurance plan the necessary forms will be completed to help expedite insurance carrier payments. It is the patients responsibility to pay all fees, co-payments, deductibles and or co-insurance when services are rendered, unless other arrangements have been made in advance with our office. It is also the responsibility of the patients to secure the necessary referrals from his/her primary care physician.

I have been made aware of the Health Insurance Portability and Accountability Act (HIPPA) **HIPAA** which protects an individual's health information and his/her demographic information ensuring the privacy and security of individual identifiable information. A copy of said policy has been presented to me for viewing.

Patient Name: _____ Patient Signature: _____

Date: _____