David G. Robbins, DPM, FACFAS
REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Wid

Birth date: / / Age: Sex: ❑ M ❑ F

Home phone #: ( )

Street address: Social Security #:

Cell Phone #:

City: State: ZIP Code: ( )

Occupation: Employer: Employer phone #:

Referral Needed: ❑ Y ❑ N Race: Hispanic ❑ Non Hispanic ❑ (please check one) ( )

Primary Physician: Primary Physician Phone: ( )

Date of Last Physical: **Referred by:**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone: ( )

Please indicate primary insurance ❑ Medicare ❑ BC/BS ❑ The Empire Plan ❑ GHI ❑ United Health

❑ Aetna ❑ Oxford ❑ Cigna ❑ Healthcare Partners ❑ HIP ❑ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of person to contact Relationship to patient: Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. David Robbins or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

HEALTH HISTORY QUESTIONNAIRE
David G. Robbins, DPM, FACFAS

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name	**DOB:**

Height: Weight:

PERSONAL HEALTH HISTORY

Are you a smoker: ☐ Y ☐ N	Pacemaker: ☐ Y ☐ N Defibrillator: ☐ Y ☐ N	Diabetes: ☐ Y ☐ N

REASON FOR TODAYS VISIT:

Medical Conditions:

Surgeries/ Hospitalizations:

Year	Reason	Hospital

List your prescribed drugs:

Name the Drug	Strength	Frequency Taken

Allergies to medications or other:

Name the Drug	Reaction You Had

Pharmacy Name and address:

_____

Obligations that we have:

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.
We are required by law to abide by the terms of this notice as long as it is currently in effect.
We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office and copies will be available there.
If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to:

David G. Robbins, DPM, CWS, FADFAS
4683 Merrick Road
Massapequa, New York, 11758

No regulatory actions will be taken against you for any complaints you may make.

I have received a paper copy of this notice.

Signature

Printed Name

Date

I make the following special request for confidential communications:

Signature Date