

FEET FIRST FOOT CARE SPECIALISTS, LLC ADAM MUCINSKAS, DPM

162 WEST STREET SUITE K CROMWELL, CT 06416
Phone: 860-632-5499 Fax: 860-632-5515
Diplomat American Board of Foot and Ankle: Certified in Foot Surgery

Date					
Name		Age	Date of Birth		
			~•		
Address	7:	(City		
State	Zip				
Phone (day)	(evening)				
e-mail address (for appointm	nent reminders):				
Occupation					
Employer			City		
State					
Social Security Number					
Emergency Contact				_	
Emergency Contact Phone (day)	(evening)			<u> </u>	
Who may we thank for referring you to this office?					
Insurance Information					
Primary InsuranceID Number	Group Numl	ner .		_	
Name on account		JCI			
Name on account					
Secondary Insurance					
ID Number	Group Numl	oer			
Name on account					
Family Physician					
Address					
Date of last exam					
Pharmacy Name		F	Phone:		
					
Please list any medications	you are currently takin	g:			
Medication	Dose	Medication	on	Dose	

Height: Weight: Shoe Size: Please describe current foot problems: Do you have a family history of any of the following? Diabetes High blood pressure Have you ever experienced any of the following? Stomach problems Varicose veins Congestive heart failure Asthma Numbness Emphysema Strokes Cancer Arthritis Spinal problems Arthritis Spinal problems Arthritis Spinal problems Anemia Heart attack Bleeding disorders Rapid heart beat Diabetes High blood pressure Other: Please list: Do you smoke? If so, how much? Any history of drug or alcohol use? If so, please explain: Assignment and release: I hereby authorize payment directly to Dr. Adam Mucinskas all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible fo all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Signature of Responsible Party Date	Are you allergic to Allergen:	any medications?	If so, please list: es, Difficulty Breathing, Anaphylaxis, Other):
Do you have a family history of any of the following? Diabetes Cancer High blood pressure Have you ever experienced any of the following? Stomach problems Ulcers Congestive heart failure Liver problems Numbness Strokes Strokes Seizures Arthritis Spinal problems Visual problems Heart attack Rapid heart beat High blood pressure Other: Please list: Do you smoke? If so, how much? Any history of drug or alcohol use? If so, please explain: Please whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.			
Diabetes Cancer High blood pressure Have you ever experienced any of the following? Stomach problems Varicose veins Ulcers Congestive heart failure Liver problems Asthma Emphysema Strokes Cancer Seizures Cancer Seizures Arthritis Spinal problems Acativate Visual problems Anemia Heart attack Bleeding disorders Rapid heart beat Diabetes High blood pressure Other: Please list: Do you smoke? If so, how much? Any history of drug or alcohol use? If so, please explain: Please list any history of surgeries or hospitalizations Assignment and release: I hereby authorize payment directly to Dr. Adam Mucinskas all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible fo all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	Please describe cur	rent foot problems:	
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Stomach problems Ulcers Congestive heart failure Liver problems Asthma Strokes Strokes Seizures Seizures Arthritis Spinal problems Heart attack Rapid heart beat High blood pressure Other: Please list: Do you smoke? If so, how much? Any history of drug or alcohol use? If so, please explain: Please list any history of surgeries or hospitalizations Assignment and release: I hereby authorize payment directly to Dr. Adam Mucinskas all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible fo all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	Cancer		High blood pressure
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Dignature of Responsible Party Date	I hereby au otherwise payable all charges whether dependents. I authorize office to release an of this signature or	thorize payment directly to to me for services rendered r or not paid by insurance, the above noted doctor and y information required to so a all insurance submissions	d. I understand that I am financially responsible for for all services rendered on my behalf or my d/or any provider or supplier of services in this secure the payment of benefits. I authorize the use