# Dr . Kane & Associates, P.C.

**WE ARE PLEASED TO HAVE YOU WITH US.**

**Dr. Kane and staff wish to welcome you to our office. Please answer these questions to help us become better acquainted. If you need any help, please do not hesitate to ask.**

**PATIENT'S NAME**_____ **DATE OF BIRTH**_____

**ADDRESS**_____ **APT/UNIT#**_____

**CITY**_____ **STATE**_____ **ZIP**_____

**SOCIAL SECURITY #**_____ **DRIVER'S LIC/STATE ID#**_____

**HOME PHONE**_____ **CELL**_____ **E-MAIL**_____

**SINGLE**_____ **MARRIED**_____ **DIVORCED**_____ **SEPARATED**_____ **WIDOWED**_____

**REFERRED BY**_____ **PRIMARY PHYSICIAN**_____

**PHARMACY**_____ **LOCATION**_____ **PHONE#**_____

**IN CASE OF EMERGENCY, NOTIFY:**_____ **PHONE**_____

**PATIENT OR GUARDIAN'S EMPLOYER**_____

**OCCUPATION** _____

**EMPLOYER'S ADDRESS**_____

**EMPLOYER'S PHONE NUMBER** _____ **EXT:**_____

## MEDICAL INSURANCE

**INSURANCE**_____

**CARD HOLDER'S NAME**_____

**RELATIONSHIP TO PATIENT: SELF**_____ **SPOUSE** _____ **PARENT** _____ **OTHER**_____

**CARD HOLDER'S SOCIAL SECURITY NUMBER:** _____ **BIRTH DATE**_____

**CARD HOLDER'S EMPLOYER'S NAME, ADDRESS AND PHONE NUMBER:**_____

_____

## Dr. Kane and & Associates, P.C.

**The questions below are required by the Affordable Health Care Act and are necessary for our practice to be and remain compliant**

**LANGUAGE:** _____

**RACE:** _____

**HISPANIC OR NON-HISPANIC (circle one)**

**SMOKER OR NON-SMOKER (circle one) PACKS PER DAY_____HOW MANY YEARS_____**

**WHEN DID YOU QUIT?** _____

**ARE YOU A DIABETIC?** _____**IF SO, TYPE I OR TYPE II. (circle one)**

**DO YOU WANT ELECTRONIC ACCESS TO YOUR RECORDS? Yes No (circle one)**

**IF SO, YOUR SECURITY QUESTION IS : KANE**

**THE ANSWER IS: YES**

**I hereby give my permission to Dr. Kane and Associates, P.C. and any associates to administer treatment and to perform general procedures as may be deemed necessary in the diagnosis and/or treatment of my foot conditions.**

**DATE_____Patient/Parent or Legal Guardian Signature** _____

**INSURED OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.**

**SIGNED_____DATE_____**

**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to Dr. Kane & Associates, P.C.**

**SIGNED_____**

**I,_____#_____request payment of authorized Medicare benefits be made on my behalf to Dr. Kane & Associates, P.C. for any services furnished to me by him or his associates. I authorize any holder of medical information about me to release to HCFA and it's agents any information needed to determine those benefits payable for related services.**

**Signature_____DATE_____**

**c:/questionaire**