

**MITCHELL A. GREENBAUM, D.P.M., F.A.C.F.A.S.**

**BOARD CERTIFIED FOOT SPECIALIST  
DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY**

**JULIA A. RABADI, D.P.M.**

**PODIATRIST  
FOOT SPECIALIST**

Have you ever had: (Please check)

Asthma: \_\_\_\_\_ Heart Problem: \_\_\_\_\_  
Bruising or Bleeding: \_\_\_\_\_ Cancer: \_\_\_\_\_  
High blood pressure: \_\_\_\_\_ Hepatitis: \_\_\_\_\_  
Stomach Ulcer: \_\_\_\_\_ Liver Disease: \_\_\_\_\_  
Hiatus Hernia: \_\_\_\_\_ Diabetes: \_\_\_\_\_  
Gout: \_\_\_\_\_ Seizure: \_\_\_\_\_  
Thyroid problems: \_\_\_\_\_ Back Pain: \_\_\_\_\_  
Kidney Disease: \_\_\_\_\_ Sciatica: \_\_\_\_\_  
Arthritis: \_\_\_\_\_ Paralysis: \_\_\_\_\_  
Reaction to anesthesia: \_\_\_\_\_ HIV: \_\_\_\_\_  
Mitral Valve Prolapse: \_\_\_\_\_ Circulation problems: \_\_\_\_\_  
Replacements or Implants; knee or hip: \_\_\_\_\_  
Other: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_  
Do you take antibiotics before you go to the dentist? \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ ID# \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_

RESPONSIBLE PARTY \_\_\_\_\_

RESPONSIBLE PARTY'S DATE OF BIRTH \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I \_\_\_\_\_  
assign directly to the Doctor all insurance benefits, if any, otherwise payable  
to me for services rendered. I understand that I am financially responsible for all  
charges whether or not paid by insurance. I hereby authorize the doctor to release  
all information necessary to secure the payment of benefits. I authorize the use of  
this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship Date

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