FOOT ASSOCIATES
NEW YORK

TZVI BAR-DAVID, DPM
ROBERT FRIDMAN, DPM

PATIENT INFORMATION

TODAY'S DATE:			FOR OFFICE USE CHART #:
LAST NAME:		FIRST:	
BIRTH DATE:	AGE:	SEX: ❑ M ❑ F	TITLE:❑ MR. ❑ MRS.❑ MISS ❑ MS. ❑ Dr.
STREET ADDRESS/ APT#:			
CITY:	STATE:		ZIP CODE:
HOME PHONE #:		WORK PHONE #:	
CELL PHONE #:		EMAIL:	
OCCUPATION:		EMPLOYER:	
EMERGENCY CONTACT NAME:		INSURANCE CARRIER & ID #:	
PHONE #:		RELATIONSHIP:	

PHYSICIAN AND REFERRAL INFORMATION

WHO REFERRED YOU TO OUR PRACTICE?

- ❑ PHYSICIAN: _____
- ❑ FRIEND: _____
- ❑ FAMILY
- ❑ CLOSE TO HOME/WORK
- ❑ INSURANCE PLAN
- ❑ INTERNET/WEBSITE
- ❑ ZOC DOC
- ❑ OTHER: _____

NAME OF PRIMARY PHYSICIAN: _____

PHONE NUMBER OF PRIMARY PHYSICIAN: _____

ADDRESS OF PRIMARY PHYSICIAN: _____

PHARMACY NAME: _____

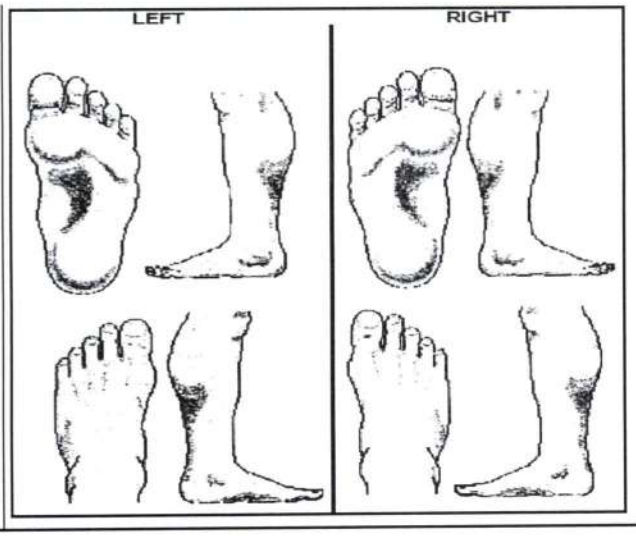
PHARMACY PHONE #: _____

PHARMACY ADDRESS: _____

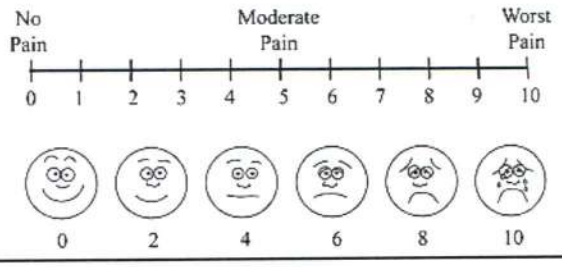
WHAT COMPLAINT BRINGS YOU TO THE DOCTOR TODAY? _____

_____

PLEASE CIRCLE THE AREA(S) THAT YOU HAVE PAIN OR ARE CONCERNED ABOUT:



CIRCLE OR MARK WHAT LEVEL OF PAIN YOU ARE HAVING:



HOW LONG HAVE YOU BEEN HAVING THIS PROBLEM? _____

HOW HAVE YOU PREVIOUSLY TREATED THIS PROBLEM? _____

PLEASE CHECK IF YOU ARE CURRENTLY BEING TREATED FOR, OR HAVE HAD, ANY OF THE FOLLOWING:

❑ ARTHRITIS	❑ CANCER (indicate if resolved):
❑ BACK PAIN	❑ BLEEDING/CLOTTING DISORDERS
❑ ARTIFICIAL JOINTS	❑ BLOOD CLOTS/DVT/PULMONARY EMBOLUS
❑ GOUT	❑ PERIPHERAL VASCULAR DISEASE
❑ DIABETES	❑ HEART DISEASE/HEART ATTACK
❑ FOOT ULCERS/INFECTION	❑ HIGH BLOOD PRESSURE
❑ NEUROLOGICAL OR NERVE DISORDERS	❑ HIGH CHOLESTEROL
❑ MIGRAINES/HEADACHES	❑ HEART MURMUR
❑ STROKE/TIA	❑ KIDNEY PROBLEMS/KIDNEY STONES
❑ HEPATITIS (circle type): A B C	❑ STOMACH ULCERS OR REFLUX (GERD)
❑ PSYCHIATRIC CARE	❑ THYROID ISSUES
❑ DEPRESSION	❑ HIV/AIDS
❑ ANXIETY DISORDER	❑ SUBSTANCE ABUSE
❑ FIBROMYALGIA	❑ OTHER:
❑ LUNG DISEASE	❑ OTHER:
❑ ASTHMA	❑ OTHER:

CURRENT MEDICATIONS

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
❑			❑		
❑			❑		
❑			❑		
❑			❑		
❑			❑		
❑			❑		
❑			❑		

PLEASE CHECK OR LIST ANY ALLERGIES IN THE APPROPRIATE BOX BELOW

❑ PENICILLIN	❑ LATEX
❑ CODEINE	❑ SHELLFISH
❑ ASPIRIN	❑ METALS (STEEL, NICKEL)
❑ NSAIDS (ADVIL, MOTRIN, IBUPROFEN)	❑ TAPE ON SKIN
❑ IODINE	❑ SEASONAL ALLERGIES
❑ SULFA DRUGS	❑ OTHER:

SOCIAL HISTORY

DO YOU CURRENTLY SMOKE TOBACCO CIGARETTES?	❑ YES	❑ NO
DO YOU CURRENTLY USE ANY ILLICIT DRUGS?	❑ YES	❑ NO
DO YOU CURRENTLY DRINK ALCOHOL EXCESSIVELY?	❑ YES	❑ NO
HAVE YOU EVER BEEN IN A DRUG OR ALCOHOL REHAB PROGRAM?	❑ YES	❑ NO

SURGICAL HISTORY (IF YES, LIST TYPE OF SURGERY)

❑ FOOT SURGERY	❑ CANCER SURGERY (list type)
❑ KNEE SURGERY	❑ CIRCULATION SURGERY
❑ HIP SURGERY	❑ BRAIN SURGERY
❑ BACK SURGERY	❑ ABDOMINAL SURGERY
❑ HEART SURGERY	❑ OTHER:

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF DIABETES?	❑ YES	❑ NO
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF HEART DISEASE?	❑ YES	❑ NO
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF BLOOD CLOTS?	❑ YES	❑ NO

REVIEW OF SYSTEMS

ARE YOU CURRENTLY HAVING OR HAVE YOU PREVIOUSLY HAD PROBLEMS WITH:
(Please check the appropriate symptoms that apply)

CONSTITUTIONAL	❑ LOSS OF APPETITE ❑ GAIN OR LOSS OF WEIGHT ❑ FEVER ❑ DIFFICULTY SLEEPING	❑ CHILLS ❑ FEELING WEAK ❑ FATIGUE
SKIN	❑ ITCHING ❑ RASH ❑ HIVES	❑ SKIN CANCER ❑ SKIN ULCER
CHEST/LUNGS	❑ CHEST PAIN ❑ SWELLING OF THE LEGS ❑ PALPITATIONS ❑ SHORTNESS OF BREATH	❑ HEART ATTACK ❑ DIFFICULTY BREATHING ❑ SLEEP APNEA
MUSCULOSKELETAL	❑ JOINT PAIN ❑ NECK PAIN ❑ BACK PAIN ❑ AMBULATORY DIFFICULTIES	❑ MUSCLE PAIN ❑ JOINT STIFFNESS ❑ SWELLING
NEUROLOGICAL	❑ FAINTING ❑ DIZZINESS ❑ MOTOR WEAKNESS ❑ CHANGE IN MOODS ❑ SEIZURE	❑ ATAXIA ❑ TINGLING/BURNING ❑ MEMORY LOSS ❑ CHANGE IN SPEECH
HEME/LYMPH	❑ ANEMIA ❑ BRUISE EASILY	❑ BLEEDING ❑ SWELLING

PATIENT ATTESTATION

I HEREBY ATTEST THAT THE INFORMATION PROVIDED IN THE REGISTRATION FORM AND MEDICAL HISTORY IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE:	DATE:

Foot Associates of New York, PC

Financial Policy

I authorize Foot Associates of New York, P.C. ("Foot Associates") to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, and to any other insurance or managed care company covering me or my dependents or insurance beneficiaries, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare, insurance or managed care benefits for services rendered to me (my dependents or insurance beneficiaries, as applicable), be made directly to Foot Associates. If my insurance plan will not assign benefits to Foot Associates, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan. I understand that I am responsible for all deductible, co-payment and co-insurance amounts and for all non-covered services. I further understand and agree that if my insurance plan sends payment to me rather than Foot Associates, I will immediately endorse the check to Foot Associates and forward it to Foot Associates to be cashed and applied to my account.

Patient Name_____

Patient Signature_____Date_____

Foot Associates of New York, PC

Health Information - HIPPA

I hereby consent and authorize Foot Associates to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, by and to its workforce members, health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Foot Associates.

I understand that, for example, my health information may be used or disclosed by Foot Associates to: provide for my care and treatment, including the filling and supplying of prescriptions; communicate among various health care professionals who are involved in my care or treatment; obtain payment for care and treatment provided by Foot Associates; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations.

I have read and understand Foot Associates' HIPAA Notice of Privacy Practices, which is available in the office and contains information on the uses and disclosures of my protected health information. I understand that Foot Associates has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Foot Associates will post a new notice in the office. I may contact Foot Associates at any time to obtain a current copy of the HIPAA Notice of Privacy Practices.

I agree that Foot Associates may disclose my protected health information to a family member, close personal friend, or other caregiver, who is involved with my healthcare and/or payment relating to my healthcare. In that case, Foot Associates will disclose only information that is directly relevant to the person's involvement with my healthcare and/or payment relating to my healthcare unless I request otherwise. I agree that Foot Associates may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist Foot Associates in carrying out its business and healthcare operations including, but not limited to, appointment reminders, insurance items, any clinical care matters and laboratory results. Foot Associates may also mail such information to my home or other designated locations.

Patient Name_____

Patient Signature_____Date_____