

AFFILIATED PODIATRISTS, LTD.



Drs. Harold Feder • Joel Feder • Marc Feder • Steven Miller • Ralph Esposito

WELCOME TO OUR OFFICE

NAME _____
LAST FIRST

ADDRESS _____
STREET APT # CITY STATE ZIP

HOME PHONE (____) _____ WORK PHONE (____) _____ E-MAIL _____

AGE ____ BIRTHDATE _____ SOCIAL SECURITY # ____ - ____ - ____ DRIVER'S LICENSE # _____

SEX (circle) M F HEIGHT _____ WEIGHT _____ SHOE SIZE _____

YOUR OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMERGENCY CONTACT _____ (____) _____
NAME PHONE

MARITAL STATUS (circle) S M W D NAME OF SPOUSE _____

DO YOU HAVE HEALTH INSURANCE? YES NO *if yes, we'll need to copy your card(s).*

IS IT YOUR POLICY? YES NO WHOSE POLICY IS IT? _____

ARE YOU COVERED UNDER ANY OTHER ADDITIONAL HEALTH INSURANCE PLANS? YES NO

GUARANTOR (RESPONSIBLE PARTY FOR THIS ACCOUNT OR CUSTODIAL PARENT) *complete if different than above*

NAME _____ (____) _____

ADDRESS _____ GUARANTOR'S SOCIAL SECURITY _____ - _____ - _____ GUARANTOR'S BIRTHDATE _____

GUARANTOR'S EMPLOYER _____ (____) _____

NAME ADDRESS PHONE

• If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility.

All unpaid balances and/or denied claims are your responsibility.

NAME OF PRIMARY INSURANCE _____

NAME OF SECONDARY INSURANCE _____

NAME OF ADDITIONAL INSURANCE PLANS _____

PHYSICIAN'S NAME _____ PHONE (____) _____ FAX (____) _____

PHYSICIAN'S HOSPITAL AFFILIATION _____ DATE OF LAST VISIT _____

WHO REFERRED YOU TO OUR CARE? _____

● **WHAT IS YOUR FOOT PROBLEM?** _____

● **FOR HOW LONG HAVE YOU HAD THE PROBLEM?** _____ HAVE YOU BEEN TREATED FOR IT? YES NO

BY WHOM? _____

IS YOUR FOOT PROBLEM THE RESULT OF A WORK-RELATED INJURY? YES NO

Medical Information

Past Medical History

Have you ever had any of the following?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fevers over 103° | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Blood/Plasma Transfusions | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Ear/Nose/Throat Problems | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |

Previous Hospitalizations/Surgeries/Serious Illness (and When?) _____

What medications &/or vitamins are you taking now and what dose? _____

(Women) Are you pregnant? Yes No Are you taking Birth Control Pills? Yes No

Are you under the care of a physician? Yes No If yes, for what reason(s)? _____

Social History

Do you live alone? Yes No For how long? _____

Do you have children? Yes No If yes, how many? _____

Do you exercise? Yes No If yes, how often? _____ What kind of exercise? _____

Are you on a special diet? Yes No If yes, what kind? _____

Do you smoke? Yes No If yes, how many packs per day? # _____ for # _____ years.

If no, when did you quit? _____ How many packs had you smoked? # _____ per day for # _____ years.

Do you drink alcohol? Yes No How much _____ Daily _____ Weekly _____ Monthly _____ Yearly _____

Do you have a history of substance abuse? Yes No What substance(s)? _____

Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Circulatory Disease _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Neurological Problems _____ | <input type="checkbox"/> Skin Disease _____ | <input type="checkbox"/> Foot Problems _____ |

Additional space, if necessary _____

Review of Systems

Please indicate any personal history below, circle:

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> ● Constitutional Symptoms Good general health lately No Yes Recent weight change No Yes Fever No Yes Fatigue No Yes Headaches No Yes ● Eyes Eye disease or injury No Yes Wear glasses/contact lenses No Yes Blurred or double vision No Yes ● Ears/Nose/Mouth/Throat Hearing loss or ringing No Yes Earaches or drainage No Yes Sinus problem No Yes Nose bleeds No Yes Mouth sores No Yes Bleeding gums No Yes Bad breath or bad taste No Yes Sore throat or voice change No Yes Swollen glands in neck No Yes ● Cardiovascular Heart trouble No Yes Chest pain or angina No Yes Palpitation No Yes Shortness of breath w/exertion No Yes Swelling of feet, ankles or hands No Yes ● Respiratory Chronic or frequent coughs No Yes Spitting up blood No Yes Shortness of breath No Yes Wheezing No Yes | <ul style="list-style-type: none"> ● Gastrointestinal Loss of appetite No Yes Change in bowel movements No Yes Nausea or vomiting No Yes Frequent diarrhea No Yes Painful bowel movements or constipation No Yes Rectal bleeding or blood in stool No Yes Abdominal pain No Yes ● Genitourinary Frequent urination No Yes Burning or painful urination No Yes Blood in urine No Yes Change in force or strain when urinating No Yes Incontinence or dribbling No Yes Kidney stones No Yes Sexual difficulty No Yes Male - testicle pain No Yes Female - pain with periods No Yes Female - irregular periods No Yes Female - vaginal discharge No Yes Female - # of pregnancies _____ Female - # of miscarriages _____ Female - date of last pap smear _____ ● Musculoskeletal Joint pain No Yes Joint stiffness or swelling No Yes Weakness of muscles or joints No Yes Muscle pain or cramps No Yes Back pain No Yes Cold extremities No Yes Difficulty in walking No Yes | <ul style="list-style-type: none"> ● Integumentary (skin, breast) Rash or itching No Yes Change in skin color No Yes Change in hair or nails No Yes Varicose veins No Yes Breast pain No Yes Breast lump No Yes Breast discharge No Yes ● Neurological Frequent or recurring headaches No Yes Light headed or dizzy No Yes Convulsions or seizures No Yes Numbness or tingling sensations No Yes Tremors No Yes Paralysis or weakness No Yes Head injury No Yes ● Psychiatric Memory loss or confusion No Yes Nervousness No Yes Depression No Yes Insomnia No Yes ● Endocrine Glandular or hormone problem No Yes Excessive thirst or urination No Yes Heat or cold intolerance No Yes Skin becoming drier No Yes Change in hat or glove size No Yes ● Hematologic/Lymphatic Slow to heal after cuts No Yes Bleeding or bruising tendency No Yes Anemia No Yes Phlebitis No Yes Past transfusion No Yes Enlarged glands No Yes |
|--|--|--|

Allergies

Do you have a history of skin reaction or other adverse reaction to:

- | | | | |
|--------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Environmental Substances | <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Foods | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tape |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> IV Dye | <input type="checkbox"/> Silver | <input type="checkbox"/> Other _____ |

Specify above and any others: _____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors' office of any changes in my medical status. I, hereby, give my permission to the Doctors of AFFILIATED PODIATRISTS to diagnose and administer treatment of my foot condition.

Signature _____ Date _____ Reviewed by: _____

AFFILIATED PODIATRISTS, LTD.



PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Affiliated Podiatrists, Ltd. and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. _____
(initial)

CONSENT FOR PHOTOGRAPHS. I grant permission for photographs to be taken to assist in documenting my condition. _____
(initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____
(initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE.

I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

(initial)

PRIVACY POLICY. I acknowledge having received the Practice's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. _____
(initial)

Patient or Authorized Person Signature

Relationship

Date