

PALISADES PODIATRY ASSOCIATES, LLP

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REGISTRATION FORM (Please print clearly)

Today's Date ___/___/___ PLEASE FILL IN DATE

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss
Street Address		City	State	Zip Code
Home Phone # () -	Work Phone # () -	Cell Phone # () -	Email Address:	
Date of Birth / /	Age	Social Security # / /	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced	Gender <input type="checkbox"/> M <input type="checkbox"/> F

INSURANCE INFORMATION

Occupation	Insured's Employer
Insured's Employer's Address	

Please indicate primary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Co-Payment Amount \$
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Insured's Birth Date / /			

Please indicate secondary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Co-Payment Amount \$
Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Insured Birth Date / /			

Does your plan require a referral? Yes No
If Yes, was a referral obtained? Yes No
Referral #:

FAMILY PHYSICIAN INFORMATION

Medical Doctor's Name		Medical Doctor's Phone Number () -		
Medical Doctor's Street Address		City	State	Zip Code
Date of last physical exam / /		Date of last blood test / /		

WHO REFERRED YOU TO OUR PRACTICE?

<input type="checkbox"/> Doctor	_____	<input type="checkbox"/> Friend	_____
<input type="checkbox"/> Hospital	_____	<input type="checkbox"/> Website	_____
<input type="checkbox"/> Insurance Plan	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Family	_____		_____

PALISADES PODIATRY ASSOCIATES, LLP

MEDICAL HISTORY

PATIENT NAME	BIRTH DATE	/ /
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ALLERGIES *(LIST KNOWN ALLERGIES TO DRUGS/MEDICATIONS – AND SPECIFIC REACTIONS TO THEM)*

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Iodine on Skin	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Tape	<input type="checkbox"/> Anti-inflammatory Medication	<input type="checkbox"/> Other:	

If any allergies, what type of reaction? Difficulty breathing Rash Stomach upset

MEDICATIONS *CURRENT MEDICATIONS YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	MEDICATION	MEDICATION	MEDICATION

FOOT AND ANKLE HISTORY

What foot/ankle problem brings you to the doctor? How Long? Shoe Size:

How have you been treated for the current problem?

<input type="checkbox"/> Surgery	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Oral Medications	<input type="checkbox"/> Cortisone Shots
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Do you have an X-Ray, MRI, or CT Scan for the current problem? Yes No

Blood Pressure Height Weight

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT

Arthritis/Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	H.I.V. Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetic Foot Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric/Psychological Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Ulcers / Reflux / Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease or Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	<input type="text"/>	
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	<input type="text"/>	
Hepatitis (Indicate) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	<input type="text"/>	

Do you drink? Yes No If Yes, Drinks per week

Do you smoke? Yes No If Yes, Pack(s)/day

Are you pregnant? Yes No

PATIENT NAME	BIRTH DATE	/ /
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INDICATE ANY SURGERY YOU HAVE HAD IN THE PAST

Orthopedic/Podiatric	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Circulation (Bypass, Angioplasty)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aneurysm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tumor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Head and Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:		
Have you ever been put to sleep for surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No			Any problems with anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY HISTORY

<i>Relative</i>	<i>Alive</i>	<i>Deceased</i>	<i>Age Deceased</i>	<i>Cause of Death (Heart Problems, Cancer, Diabetes, Etc.)</i>
Father	<input type="checkbox"/>	<input type="checkbox"/>		
Mother	<input type="checkbox"/>	<input type="checkbox"/>		
Siblings	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

MEDICAL HISTORY AFFIRMATION

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X	/ /
Patient/Guardian Signature	Date

History Reviewed By: Dr. Signature	Date
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ASSIGNMENT AGREEMENT

Our office has agreed to bill your insurance company for payment of your office visit/s. The patient is responsible for all co-payment and deductibles specified by the insurance company. I request that payment of authorized insurance benefits be made to:

Palisades Podiatry Associates, LLP

Signature of Patient or Legal Guardian

Patient's Name

Date

EMERGENCY CONTACT INFORMATION

NAME : _____

RELATIONSHIP: _____

HOME PHONE: (____) _____

WORK NUMBER: (____) _____

CELL NUMBER: (____) _____

Palisades Podiatry Associates, LLP

11 Medical Park Drive Suite 206
Pomona, New York 10970
(845)362-0100

PATIENT HIPAA AWARENESS

With my permission, Dr. Barry Schoenberg, Dr. Jeffrey Horowitz and Dr. Sharon Weibman of Palisades Podiatry Associates, LLP, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Palisades Podiatry Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Palisades Podiatry Associates, LLP reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, Palisades Podiatry Associates, LLP 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 the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, Palisades Podiatry Associates, LLP may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, Palisades Podiatry Associates, LLP may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Palisades Podiatry Associates, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Palisades Podiatry Associates, LLP to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian