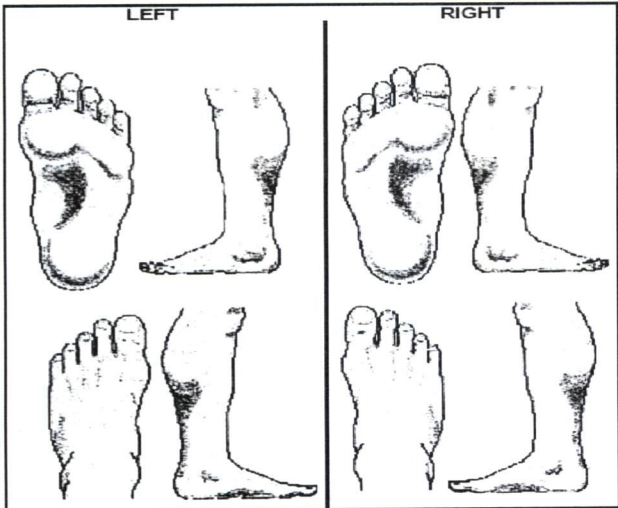
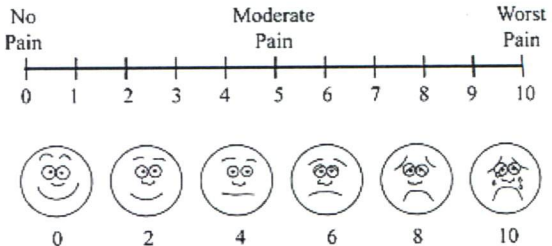


PATIENT INFORMATION			
TODAY'S DATE:			FOR OFFICE USE CHART #:
LAST NAME:		FIRST:	
BIRTH DATE:	AGE:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	TITLE: <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS <input type="checkbox"/> MS. <input type="checkbox"/> 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? <input type="checkbox"/> PHYSICIAN: _____ <input type="checkbox"/> FRIEND: _____ <input type="checkbox"/> FAMILY <input type="checkbox"/> CLOSE TO HOME/WORK <input type="checkbox"/> INSURANCE PLAN <input type="checkbox"/> INTERNET/WEBSITE <input type="checkbox"/> ZOC DOC <input type="checkbox"/> OTHER: _____	NAME OF PRIMARY PHYSICIAN: _____ PHONE NUMBER OF PRIMARY PHYSICIAN: _____ ADDRESS OF PRIMARY PHYSICIAN: _____ PHARMACY NAME: _____ PHARMACY PHONE #: _____ PHARMACY ADDRESS: _____
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WHAT COMPLAINT BRINGS YOU TO THE DOCTOR TODAY? _____

PLEASE CIRCLE THE AREA(S) THAT YOU HAVE PAIN OR ARE CONCERNED ABOUT:	<div style="display: flex; justify-content: space-around;"> LEFT RIGHT </div> 	CIRCLE OR MARK WHAT LEVEL OF PAIN YOU ARE HAVING: <div style="display: flex; justify-content: space-between;"> No Pain Moderate Pain Worst Pain </div> 
---	---	--

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:

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

CURRENT MEDICATIONS

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>		

PLEASE CHECK OR LIST ANY ALLERGIES IN THE APPROPRIATE BOX BELOW

<input type="checkbox"/> PENICILLIN	<input type="checkbox"/> LATEX
<input type="checkbox"/> CODEINE	<input type="checkbox"/> SHELLFISH
<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> METALS (STEEL, NICKEL)
<input type="checkbox"/> NSAIDS (ADVIL, MOTRIN, IBUPROFEN)	<input type="checkbox"/> TAPE ON SKIN
<input type="checkbox"/> IODINE	<input type="checkbox"/> SEASONAL ALLERGIES
<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> OTHER:

SOCIAL HISTORY

DO YOU CURRENTLY SMOKE TOBACCO CIGARETTES?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU CURRENTLY USE ANY ILLICIT DRUGS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU CURRENTLY DRINK ALCOHOL EXCESSIVELY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HAVE YOU EVER BEEN IN A DRUG OR ALCOHOL REHAB PROGRAM?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SURGICAL HISTORY (IF YES, LIST TYPE OF SURGERY)

<input type="checkbox"/> FOOT SURGERY	<input type="checkbox"/> CANCER SURGERY (list type)
<input type="checkbox"/> KNEE SURGERY	<input type="checkbox"/> CIRCULATION SURGERY
<input type="checkbox"/> HIP SURGERY	<input type="checkbox"/> BRAIN SURGERY
<input type="checkbox"/> BACK SURGERY	<input type="checkbox"/> ABDOMINAL SURGERY
<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> OTHER:

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF DIABETES?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF HEART DISEASE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF BLOOD CLOTS?	<input type="checkbox"/> YES <input type="checkbox"/> NO

REVIEW OF SYSTEMS

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

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