# WELCOME TO OUR OFFICE

| Last Name: | First Name: | Mi | Date Of Birth: |
|---|---|---|---|
| Home Address: City State Zip | | Social Security Number: | |
| Email Address: | Home phone: | Cell phone: | |
| Spouse's Name/or Parent's/Guardian Name if patient is a minor: | | Marital Status: | |
| Name of Employer: | Work phone number: | Occupation/Business Address: | |
| Whom may we thank for referring you? | Did you find us in the Internet? (if so please check where)<br>___Google ___MSN ____Insurance Web site ___Other_____ | | |
| Name and address of person to contact in case of emergency: | Phone: | Relationship: | |
| Do you Have Medical Insurance?<br>___Yes ____No | Name of Insurance Company | Policy I.D. Number: | |
| Patient Relationship to Insured<br>__Self __Spouse __Dependent | Secondary Insurance Name if Any | Secondary Policy I.D. Number: | |
| Name of Family Physician: | Phone Number: | List any conditions you may have: | |
| Have you had previous treatment<br>By a Podiatrist? ___Yes ___NO | How long ago? | For What? | |
| What is your Chief Foot Complaint? | | | |
| List all medications taken regularly or provide a copy of a list of your medications: | | | |
| | | | |

Do you have, or have you had any of the following? (Please Check All That Apply)

| | | | |
|---|---|---|---|
| Foot or Leg Injuries___<br>Foot or Leg Surgery___<br>Foot or Leg Cramps___<br>Foot or Leg Numbness___<br>Knee Pain ___<br>Unequal Leg Length___<br>Weak Ankles___<br>Bunions___<br>Foot Skin Problems___<br>Prone to Infection___ | Diabetes___<br>Heart Trouble___<br>Epilepsy___<br>Liver Disease___<br>Kidney Disease___<br>High Blood Pleasure___<br>Polio___<br>Bursitis___<br>Stomach Ulcers___<br>Varicose Veins___ | Lower Back Pain___<br>Asthma___<br>Stomach Ulcers___<br>Anemia___<br>Gout___<br>Fainting Spells___<br>Bleeder___<br>Blood Diseases___<br>Circulation Problems___<br>Arthritis___ | Are you Allergic/Sensitive to:<br>Novocain___<br>Penicillin___<br>Adhesive Tape___<br>Latex___<br>Drugs or Foods of any kind___ |

I Herby give Dr._____permission to examine and treat my feet.

Patient's and/or Parent's/Guardian's Signature_____Date:_____

# Middletown Podiatry Associates

3594 East Tremont Avenue, Suite 210
Bronx, NY, 10465
(718) 863-5511

## SIGNATURE ON FILE

**For All Insurances:**

"I here authorize any physician, health care practitioner, hospital, clinic, or medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review. Investigation or evaluation of any claim submitted to my insurance company.

I also authorize my insurance company to disclose to a hospital or health care service plan, self insurer, or any insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain effective for the duration of any claim or term of coverage with my insurance company including reasonable time thereafter, until its final consummation. The authorization shall be binding upon my dependents out heirs and me executors, and administrators."

**Medicare Patients:**

"I request that payment of authorized Medicare benefits be made to me or on behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Adminstration and its agents any information needed to determine these benefits payable for related services."

Patient(s) name:_____

Signature:_____

Health Insurance Claim Number:_____

Date:_____

# ACKNOWLEDGEMENT OF RECEIPT
# OF
# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative

_____

Signature

I consent to receive email and text messages from the office regarding my appointments and my care.

____ Yes, I would like to receive email and text messages

____ No, I refuse to receive email and text messages