

PATIENT REGISTRATION INFORMATION

Patient #: _____

PLEASE PRINT

TODAY'S DATE _____

LAST NAME: _____

FIRST NAME: _____ MI _____

ADDRESS: _____ APT# _____

CITY/STATE _____ ZIP _____

PHONE: () _____

SOCIAL SECURITY#: _____ M/F _____

DATE OF BIRTH: _____

CELL PHONE #: _____

E-MAIL ADDRESS: _____

EMPLOYMENT, PRIMARY CARE PHYSICIAN, AND PHARMACY INFORMATION

EMPLOYER: _____

OCCUPATION: _____

ADDRESS: _____

WORK PHONE: _____

WHO REFERRED YOU TO US? _____

PRIMARY CARE PHYSICIAN: Last Name: _____ First Name: _____

ADDRESS _____ PHONE # _____ FAX # _____

_____ DATE OF LAST VISIT WITH YOUR PCP: _____

*Providing **Pharmacy Information** will allow us to email the prescription directly to your pharmacy*

PHARMACY NAME: _____ PHONE: _____

STREET ADDRESS: _____ ZIP _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY NO: _____

GROUP NO: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE: () _____

SUBSCRIBER (IF OTHER THAN PATIENT)

LAST NAME: _____

FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY/STATE: _____

PHONE: () _____

EMPLOYER: _____

BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

POLICY NO: _____

GROUP NO: _____

ADDRESS: _____

CITY/STATE: _____

PHONE: () _____

EMPLOYER: _____

BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____

WHAT IS THE CHIEF COMPLAINT? _____

ARE THERE ANY OTHER FOOT OR LEG PROBLEMS? _____

FORMER PODIATRIST: _____ LAST VISIT: _____

How is your general health? Good Fair Poor

Are you now or have you ever been under a physician's care during the past two years for any reason? Yes No

If YES, for what reason? _____

Are you taking any medications at the present time? Yes No

If YES, what medication and what dosage? _____

Are you allergic or sensitive to: (Please describe your reaction to allergy that you've checked.)

Novocain Codeine Cortisone Sulfa
 Aspirin Penicillin Adhesive Tape Other: _____

Do you have or have you ever had any of the following?

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Prolonged Bleeding
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cramps or numbness (in foot or legs)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Raynaud's Disease
<input type="checkbox"/> Arthritis/Osteoarthritis	<input type="checkbox"/> Dermatologic Condition (Skin)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis, Rheumatoid	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> IBS	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Broken Bones (in foot or legs)	<input type="checkbox"/> Hardening of Arteries	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Venereal Disease

Have you ever been hospitalized: Yes No Is YES, for what reason and how long: _____

Do you smoke? Yes No If so, how many a day? _____

Have you ever had surgery: Yes No If YES, what type of surgery and what year: _____

Is there a family history of: (If YES is checked on any, please note person(s) in family.)

DIABETES: Yes No -- Mother Father Grandfather Grandmother Brother Sister

HEART DISEASE: Yes No -- Mother Father Grandfather Grandmother Brother Sister

CANCER: Yes No -- Mother Father Grandfather Grandmother Brother Sister

➤ IF YOU PARTICIPATE IN ANY SPORT(S), PLEASE COMPLETE THE FOLLOWING: (ie, exercise, walking, running, etc.)

➤ SPORT(S): _____

➤ YEARS OF SPORT(S) PARTICIPATION: _____

➤ TRAINING PER WEEK: _____ RECENT 3-5 MONTH INTENSITY: _____

➤ TIME OF DAY TRAINING: _____

➤ SHOES USED: _____ SURFACES: _____

➤ DO YOU WARM-UP WITH FLEXIBILITY EXERCISES? IF SO, FOR HOW LONG: _____

➤ INJURY: DESCRIBE INJURY AND DURATION OF INJURY: _____

➤ HAVE YOU SOUGHT OTHER MEDICAL ADVICE: _____

➤ PREVIOUS INJURIES: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient # _____

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practice 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 _____
If applicable

X Signature: _____

Assignment of Benefits:

I, the undersigned have health insurance. I assign directly to Kenneth Meisler DPM, Rocco Sellitto DPM, Karen Silver DPM, Stephanie Hochman DPM, Christopher Minacapilli DPM, Martin Wendelken, DPM all medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic to any insurance I have at this point or in the future.

X Signature: _____ **Date** _____

New Patient Information (Please print this page and follow the directions)

1. Please print the Patient Registration Information Form and fill out. The forms are two long. **PLEASE PRINT NEATLY.**
2. Please print and read the Notice Of Privacy Practices form, you can also read it online.
3. Print out and sign the Acknowledge of Receipt of Notice Privacy Practices form. It states that you were provided a copy of the Notice Of Privacy Practice and read it (or had the opportunity to read it).
4. You must sign at the two large X's on that form. The first is the HIPAA acknowledge and the second assigns benefits directly to our offices so that your insurance company will pay us directly. It also explains some of the financial arrangements of the office and allows us to use this one signature rather than having you sign at each visit. Please read the entire and sign at both X's.
5. Please make sure to bring your insurance card with you when you come to our office. We will need to make a copy of it for our records.
6. If your plan requires a referral please arrange to have one sent to us prior to your visit as referrals cannot be backdated. Please note that it is your responsibility to do this.
7. Please note that your co-pay is required at the time of visit.