CITY • PODIATRY
NEW YORK CITY

Patient Questionnaire

DATE_____

LAST NAME _____ FIRST NAME_____ MIDDLE_____
ADDRESS_____APT_____
CITY _____ STATE_____ ZIP _____
PHONE NUMBERS: HOME_____CELL_____
WORK _____ EMAIL_____
DATE OF BIRTH _____AGE_____ SEX ____RACE_____ETHNICITY_____LANGUAGE_____
STUDENT: Y___N___
Insurance ID# _____ MARITAL STATUS: S____M____D____W____
HEIGHT _____ WEIGHT_____ SHOE SIZE _____
EMERGENCY CONTACT _____
RELATIONSHIP_____ PHONE NUMBER_____
HOW WERE YOU REFERRED TO OUR OFFICE _____
OCCUPATION _____ EMPLOYER NAME AND ADDRESS _____
_____
PRIMARY CARE PHYSICIAN _____ PHONE NUMBER_____
POLICY HOLDER _____ POLICY HOLDER DOB_____
PRIMARY INSURANCE _____ ID#_____GROUP#_____
SECONDARY INSURANCE _____ID#_____GROUP#_____
REFERRAL REQUIRED: YES ____ NO ____ POLICY HOLDER EMPLOYER _____

Reason for Visit __Right Foot ___Left Foot Explain: _____

_____

Are you diabetic: Yes___No___ If Yes: Type I___ or Type II___ Controlled___ Uncontrolled___

PLEASE CHECK ALL THAT APPLY TO YOU:

__Aids/HIV
__Anemia
__Angina
__Arthritis
__Bleeding/Clotting Disorders
__Cancer
__Chemical Dependency
__Chest Pain
__Circulatory Problems
__Cramps/Numbness in Feet/Legs
__Fainting
__Gout
__Headaches
__Heart Disease
__Hemophilia
__Hepatitis
__High Blood Pressure
__High Chlolestrol
__Kidney Problems
__Low Blood Pressure
__Nervous Problems
__Phlebitis
__Psychiatric Care
__Rash
__Respiratory Disease
__Rheumatic Fever
__Shortness of Breath
__Sinus Problems
__STD
__Stroke
__Swelling-Ankles/Foot
__Tuberculosis
__Ulcers
__Varicose Veins
__Weight Loss
__Other_____

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Name _____

Allergies

__ No Known Allergies
__ Aspirin
__ Codeine
__ Egg
__ Iodine
__ IV Dye
__ Latex
__ Local Anesthetic
__ Penicillin
__ Seafood
__ Sulfa
__ Tape/Adhesive
__ Other _____

Medications

Please list any prescription and over the counter medications you are taking

Name of Medication	Dose	X/Day	Name of Medication	Dose	X/Day

Social History

___ Alcohol __Recreational Drugs
___ Smoke (Packs/day x yrs)__

PAST SURGICAL HISTORY

Please list the type of surgical procedure:
_____

Date of surgical procedure:_____

Mother's History	*Father's History*
___Heart Disease	___Heart Disease
___ Anemia	___ Anemia
___ Diabetes	___ Diabetes
___ Hypertension	___ Hypertension
___ Stroke	___ Stroke
___ Cancer	___ Cancer
Other_____	Other_____

Pharmacy Information

*****Note: Controlled Medication are not eligible for e-prescribe.*****

Name of Pharmacy: _____
Address: _____
City: _____ State: _____ Zip Code:_____
Phone: _____ Fax: _____

IS THIS A WORKERS COMPENSATION CASE YES_____ NO_____ CLAIM #_____
ADJUSTERS NAME_____
ADDRESS_____
_____
PHONE NUMBER_____

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Assigned And Release

I, undersigned, have insurance coverage with _____and assign directly to City Podiatry all medical benefits. I understand that I am financially responsible for co-insurance, co-pays, deductible or any other charges if not covered and paid by insurance. I hereby authorize City Podiatry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance claims and submissions.

_____ _____

Signature Date

Assignments of Benefits - Medicare, Medicaid & Commercial Insurance

I request that payment of authorized Medicare, Medicaid and commercial insurance benefits be made on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or any other insurer and its agents, any information needed to determine these benefits or the benefits payable for related service.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to City Podiatry, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

_____ _____

Signature Date

Please Intial below after each line

- Please call us within 24 hours to cancel or change appointment. Failure to do so may result in a $50 FEE. _____
- Patient is responsible to obtain a referral, if required. Patient may not be seen if referral is required. If seen, with no authorization, and no payment is provided by the insurance company the patient will be responsible for payment prior to being seen by the Doctor. ____
- All copays must be paid at the time of service. _____
- No EATING, DRINKING or PHONE CONVERSATIONS in the waiting area. _____
- Please do not take your shoes off in our waiting area, or feet up on the waiting area furniture. _____

Thank you for being one of our highly valued patients

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received City Podiatry's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient:_____
Print Name

_____
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- ❑ Showing the patient the Notice of Privacy Practices posted in our office.
- ❑ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ❑ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ❑ Asking the patient to sign this Acknowledgement form.
- ❑ Other (explain in detail) _____
  _____
  _____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ❑ The patient refused to sign this form.
- ❑ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ❑ Other (explain in detail) _____
  _____
  _____

Date: _____ Name:_____

Notes: This written Acknowledgement must be completed no later than the first date health care services or treatment is provided to the patient after April 14, 2003 (or Practice start-up date). This Acknowledgement must be retained in the patient's permanent records.

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Insurance Required Preventative Care and Screening Form

Name: _____ **Date**: _____

Height: _____ Weight: _____

Past Medical History: has anything changed since last visit? **Circle: YES, or NO**
If yes, please list changes:

Medications: has anything changed since last visit? **Circle: YES, or NO**
If yes, please list changes:

Allergies: has anything changed since last visit? **Circle: YES, or NO**.
If yes, please list changes:

Smoking history: **Circle one**: Current smoker or never smoked
Stopped smoking? _____(date)

Last Primary Care Physician Visit:
When _____? Doctor? _____

Flu shot: Did you get a flu shot? **Circle *YES,* or *NO***
If yes, when _____? Where? _____

Pneumonia vaccine: (people over 65): **Have you received it? Circle: *YES,* or *NO***
If yes, when _____? Where? _____

Breast Cancer Screening: have you had a mammogram **Circle: *YES,* or *NO***
If yes, when _____ where_____ what were the results _____
If no, are you scheduled for one? **Circle: YES, or NO**