Flatlands Foot Care

Talia Shwer Podiatry P.C.
2075 Flatbush Avenue
Brooklyn, NY 11234
Tel. 718-338-8715 Fax. 718-951-8606

PATIENT HISTORY

*** Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.**

Name: _____ Date of Birth: _____

Street Address: _____ Apartment/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Age: _____ Height: _____ Weight: _____ Social Security #: _____

Emergency Contact: _____ Phone: _____

1) What is the main problem with your feet or ankles? _____

_____

2) When did you first notice the condition? _____

3) Is this an injury? ____Yes ____No If Yes, when did it occur? ____/____/____

If Yes, did it happen at work? ____Yes ____No Are you claiming Workman's Comp? ____Yes ____No

4) How painful is your condition? **1** = "minimal pain/discomfort" **10** = "the worst pain you have ever experienced", please circle your pain level **1 2 3 4 5 6 7 8 9 10**

5) How has this affected your daily routine and what activities does this keep you from performing? _____

_____

MEDICATIONS **(If you have a *list* we will photocopy it in instead of filling this section out.)**

Pharmacy: _____ Number: _____-_____-_____

Medication	Dosage	How Often Taken?	What is it Taken for?

ALLERGIES ☐ **NONE** ☐ **OTHER** _____

☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Anesthetics ☐ Latex

☐ Codeine ☐ Demerol ☐ Darvocet ☐ Cortisone ☐ Environmental ☐ Food

Type of Reactions:_____

MEDICAL HISTORY

* Please ***check*** any of the following conditions that you have or have had in the past.

☐ Diabetes ☐ Hepatitis ☐ Aids (HIV) ☐ Heart Problems:_____ ☐ Stroke

☐ High Blood Pressure ☐ Lung Disease ☐ Asthma/COPD ☐ Glaucoma ☐ Stomach Ulcers ☐ Arthritis

☐ High Cholesterol ☐ Nerve Conditions ☐ Epilepsy ☐ Fibromyalgia ☐ Bleeding Problems

☐ Thyroid Disease ☐ Skin Disorders ☐ Osteoporosis ☐ Anemia ☐ Gout

☐ Kidney Problems ☐ Colitis / Crohn's ☐ Sickle Cell ☐ Mental Disorders:_____

☐ Poor Circulation ☐ Heart Burn / Reflux ☐ Sexually Transmitted Diseases ☐ Tuberculosis

☐ Cancer; type _____ Other: _____

☐ What is the name, phone number, and address of the doctor treating you for Diabetes or Primary Care?

_____

When was your last visit? ____/____/____ If Diabetic: What is your average blood sugar reading (A1c)?_____

- Are you pregnant? ____Yes ____No How many months? _____

SURGICAL HISTORY

Procedure	Date	Complications

7) Have you ever been hospitalized other than for surgery? ____Yes ____No Explain_____

_____

8) Have you ever had an injury to the lower extremity? ____Yes ____No Explain _____

_____

FAMILY HISTORY

* Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Occupation:_____

Activities: _____

Level of activity: ____Occasional ____Weekly ____Competitive ____Professional

Do you smoke tobacco? ____Yes ____No

If Yes: # packs per day? ____ # cigarettes per day? ____ # of years smoking? ____

If No: Did you ever smoke? ____Yes ____No

If Yes: How long ago did you stop smoking? _____

Do you drink alcohol? ____Yes ____No

If Yes: How much? ____< 1 per week ____1-2 per week ____1-2 per day ____more than 3 per day

Recreational drug use

* Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ____Yes ____No

If Yes: What substance and how often used? _____

REVIEW OF SYSTEMS

*If you are experiencing any of the following please circle

Head: chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears**: decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, blockage, bleeding, sinusitis. **Throat**: chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratrory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina. **Gynecologic:** Irregular or painful periods, absence of period if not in menopause, vaginal discharge.

Other: _____

- Do your legs swell? ____Yes ____No
- Do you have back problems or have had a back injury? ____Yes ____No

☐ **I am not experiencing any of the above symptoms.**

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

☐ You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment.

Signature: _____ **Date: ____/____/____**

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Signature on File Authorization

I request that payment of authorized Medicare or designated healthcare benefits be made either to me or on my behalf to Dr Talia Shwer DPM (Talia Shwer Podiatry P.C.), for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for my health insurance and its agents any information needed to determine these benefits payable for related services.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

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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).

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

Flatlands Foot Care

At Flatlands Foot Care we participate with many insurance plans. We also accept out-of-network benefits from several other plans. We can not guarantee that your insurance will cover all services. We will submit claims to the insurance company on your behalf. With the new changes in health care, many patients are now experiencing high deductibles. Patient are responsible for deductibles. We will verify your insurance for you but we cannot always determine deductibles. Sometimes, the insurance company will give us an estimate of your benefits. These are the amounts that we will use to determine deductibles and benefits.

Of note, depending on the insurance company, payment for services may be rendered to the patient or to the office. Again, we cannot determine this until after the billing has been sent out. If you receive payment for services, you are held liable for those payments and are required to submit them to the office. These amounts along with any deductibles are part of the patient responsibility. Upon request, we can give a likely estimate of the cost of patient services rendered. This is also based on your previous estimated insurance benefits as provided by your insurance company and, as such, is only an estimation.

As of April 2015, we are required by law to inform you of your insurance rights as above stated including payment of deductibles and copays which are required by your contract with your insurance company. By signing, you acknowledge that you have read the above form and have been notified herein of possible changes to insurance payments.

We do our best to keep your costs low and the service we provide at a very high level. If you have any questions, please do not hesitate to ask. We are here to improve your functionality and quality of life. Thank you for your time. We appreciate your business.

.

Signature:_____

Print Name: _____

Date:_____