Manhattan Podiatry Associates P.C.
Gramercy Podiatric Surgery Suite
REGISTRATION FORM
(Please Print)

Today's Date ____/____/____ PCP_____

PATIENT INFORMATION

Patient's Last Name	First	Middle

☐ Mr. ☐ Miss ☐Mrs. ☐ Ms	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	Birth Date / /	Gender ☐ M ☐ F

Address	APT #	Social Security #	Home Phone No. ( )
City	State ZIP Code		E-Mail Address

Occupation	Employer	Business Phone No. ( )	Cell Phone No. ( )

Ethnicity Please Circle: Native American Asian African American

Caucasian Pacific Islander Other_____ Refused to report

Primary Language_____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

NAME OF PRIMARY INSURANCE

Policyholder's name.	Policyholder's S.S.#	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐Other

NAME OF SECONDARY INSURANCE	Policyholder's Name	Group #	Policy #

Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐Other

How did you hear about our practice? ☐ Friend/College ☐ Doctors Office ☐ Internet Search ☐ Zocdoc ☐ Insurance Company ☐ Other

Current foot complaint/symptoms:

IN CASE OF EMERGENCY

Name of Local Relative or Friend	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Manhattan Podiatry or insurance company to release any information required to process my claims. I acknowledge that I was provided and read (or had the opportunity to read)and understood ***The Notice of Privacy Practice*** I am aware that the following information is available for viewing upon request;

- Information regarding the providers of care in this organization
- A copy of the Patient's Bill of Rights and Responsibilities
- Information regarding the grievance process
- Ownership of Practice
- DNR Policy
- JCAHO Information

PATIENT/GUARDIAN SIGNATURE_____ DATE_____

MEDICAL HISTORY

PATIENT'S NAME: _____ DATE: _____

	YES	NO
Have you been ill recently? EXPLAIN:		
Have you ever been hospitalized? EXPLAIN:		
Are you under the care of a Physician? EXPLAIN:		
Have you ever had surgery? EXPLAIN:		
Do you drink alcohol? How much?		
Do you have asthma? When was the last episode?		
Rheumatic Fever?		
Heart Attack (Heart Disease or Murmur) if so when? How many?		
High Blood Pressure?		
Anemia?		
Stroke? If so when?		
Jaundice?		
Diabetes? Type#1 or Type#2?		
Seizures / Epilepsy? Type? Last episode?		
Tuberculosis?		
Venereal Disease?		
Are taking medications now? Enter ALL medications on a separate list.		
Are you allergic to penicillin? Or any other medications? Please List medicine and reaction.		
Do you have prolonged bleeding?		
Are you PREGNANT OR NURSING? Circle one if applicable.		

Tobacco Usage

Please Circle the Answer that Applies:

Presently Smoke Everyday

Presently Smoke Some Days

Former Smoker

Never A Smoker

Smoker, Current Status Unknown

Unknown If Ever Smoked

UNIVERSAL MEDICATION FORM

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription Vitamin and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATIONS/DOSE	DIRECTIONS: (How many times a day do you take this and when.)	DATE STOPPED	NOTES: Reason for taking/Doctor

NAME & ADDRESS OF YOUR PHYSICIAN: _____

_____

Height_____ Weight_____ Shoe Size_____

PATIENT SIGNATURE: _____ DATE: _____

INSURANCE CHECKS SENT TO THE PATIENT

I have been informed by Manhattan Podiatry Associates that the checks from my Insurance company may be sent directly to me.

These insurance carriers will send checks to the patient:

1. **Blue Cross/Blue Shield**
2. **Oxford Health Plans**
3. **Empire Plan(Government Workers)**
4. **GHI**
5. **United Health Care**

I AGREE TO GIVE THESE INSURANCE CHECKS TO MANHATTAN PODIATRY ASSOCIATES.

I understand that these checks from my insurance company are for services provided to me by either:

- **Gramercy Podiatric Surgical Suite**
- **Anesthesiologist: Barry Cohen**
- **Fifth Ave Podiatric Surgery Suite**
- **Doctors:**

***Dr. Steven Abramow** **Dr. John E. Mancuso** **Dr. Mark Landsman**
Dr. Howard Shapiro **Dr. Howard Zaiff**

***Being a GROUP Practice the statement from the Insurance Carrier may have the name of a different doctor other than your main doctor.**

I AGREE AND ACKNOWLEDGE NOT TO CASH OR DEPOSIT THESE CHECKS.

****IN THE EVENT I FALSELY WITHOLD SUCH CHECKS I AGREE AND ACKNOWLEDGE THAT I AM ULTIMATLY RESPONSIBLE FOR THE AMOUNT OF THESE CHECKS DUE TO MANHATTAN PODIATRY OR ANY OF THE DOCTORS MENTIONED ABOVE.**

If I get insurance checks for services provided by Manhattan Podiatry Associates, Fifth Ave Podiatric Surgical Suite., Gramercy Podiatric Surgery Suite. or any of the podiatrist or Anesthesiologist I agree to forward them to Manhattan Podiatry Associates.

_____ _____ _____

Print Name Sign Name Date

GRAMERCY PODIATRIC SURGERY SUITE

DOCTOR :

ISSUED DATE_____
Dates of Review- MM/YY_____

Your Name_____
Date_____

INITIAL LEARNING ASSESSMENT

During your visit with our organization you will be presented with information that may be new to you. To aid in providing the best care possible please answer the following questions. Then return the form to the front desk. Thank You.

How do you like to learn new things? Please check ALL that apply.

	Reading		Pictures/Diagram
	Discussion		Hands on Demonstration
	Other		Self-Study

Factors that can affect Learning :	YES	NO	COMMENTS
Do you speak English in your home?			If no, what Language do you speak? Name of Interpreter;
Can you read English?			
Can you write English?			
Do you hear well?			If no, Do you utilize a hearing device? _____Yes ____No
Do you see well?			If no, Do you utilize Glasses or Contacts? ____Yes ____No
Do you have cultural or religious practices/beliefs that may affect your care/treatment?			If yes, Please explain

Other Comments;_____

_____

_____

Pharmacy Information

Patient Name:

DOB:

Any Known Drug Allergies:

Preferred Pharmacy Information

Name of Pharmacy: _____

Address: _____
Street Address

_____
City State Zipcode

Phone: _____

Fax: _____

Patient signature of consent for Electronic Medical Prescribing: _____date

Thank You
Manhattan Podiatry Associates

Consent to Text Message Appointment Reminders

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (_____) _____-_____
Carrier:_____

CREDIT CARD ON FILE AUTHORIZATION

Due to the increase in patient responsibilities for high deductible and co-insurance health plans, we are now requiring all patients to provide a credit card to store on file. Card information will be stored digitally and securely by JP Morgan Chase. We WILL NOT charge your card until after your claim has been processed by your insurance company and it is determined what your financial responsibility is.

I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my credit card account periodically to pay for amounts owed. If my credit card information listed below changes for any reason, I will notify Manhattan Podiatry Associates. In the event of a declined charge, my account will be charged a $30.00 service fee for each occurrence.

Type of Card: _ Visa _ Mastercard _Discover _Amex _ Other

Account Number:_____

Expiration Date: ___ / ___ Security Code: _____(3 or 4 digit)

Name on the Card: _____

By signing below, you authorize Manhattan Podiatry Associates, P.C. to charge your credit card 3-4 days following the receipt of the explanation of benefits from your insurance company. A receipt will be mailed to you.

Signature: _____