Jeffrey Rosenblatt, DPM, Manoj Sadhnani DPM
Diplomate, American Board of podiatric Surgery
Certified in Foot Surgery.

**PATIENT INFORMATION FORM**

Patient's Full Name: _____ Sex: F M (please circle)

Birthdate: __/____/____ Home Phone(___) ____-_____ Cell Phone (___)_____-_____

Patient's Social Security #:____-____-_____ Marital Status: S M D W (please circle)

Home Address:_____ Apt #_____ City_____
NY, Zip_____

Patient Occupation:_____

Employer:_____

Employer's Address:_____

Work Phone:_____

Spouse Name: _____ Spouse Cell Phone: _____

Spouse Social Security:_____ Spouse Work Number:_____

Emergency contact:_____ Phone Number:_____

Insurance Company & ID#: _____

Pharmacy: _____

Primary Care Physician:_____Phone #: (___)____-_____

What is your foot problem?:_____

How did you hear about us?_____

E-Mail:_____

Date:_____

I understand that honest and complete answers to each question stated below are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any questions on the form I should ask the doctor or a member of the office staff for assistance.

| **Medications** | **Yes** | **No** |
|---|---|---|
| Penicillin | | |
| Aspirin | | |
| Codeine | | |
| Adhesive Tape | | |
| Local Anesthetics | | |
| others | | |
| | | |

**Patient Medical History**

| **Conditions** | **Yes** | **No** |
|---|---|---|
| Diabetes | | |
| High Blood Pressure | | |
| Heart Disease | | |
| Arthritis | | |
| Drug Reaction | | |
| Asthma | | |

**Allergies**

| | | |
|---|---|---|
| Anemia | | |
| Hay Fever | | |

**Please List All Medications You are Currently Taking.**

_____
_____
_____

**Please List All Past Surgery with Dates**

_____
_____
_____

**Please List All Past Surgical Implants/ Hardware**

_____
_____
_ _____

**Jeffrey Rosenblatt, DPM, Manoj Sadhnani DPM**
**408 Jay Street**
**Brooklyn NY 11201.**

## Consent Information

**Consent to Treat**
**Patient Name:** **Date:**

This information I have given this office is complete and true to the best of my knowledge. I authorize the doctor and staff of Absolute Footcare P.C, to administer such procedures and treatment as they deem necessary. They have implied no guarantee or cure.

## Consent To Treat A Minor Child

The information I have given this office pertaining to _____is true and complete to the best of my knowledge. I authorize the doctor and staff of Absolute Footcare P.C, to administer

treatment as they deem necessary to my child/ward in my legal custody. The doctor have implied no guarantee of cure.
**Parent/Guardian Signature:_____ Date:**

**For Women Only** The doctor and staff member of Absolute Footcare P.C, has advised me that x-ray can be hazardous to an unborn child. At this time to the best of my knowledge, I am not pregnant. I consent to having x-rays taken.
**Patient Initials:_____ Date:**

**Payment Agreement/ Assignments Of Benefits**

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary report and forms to assist me in making collection from this insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, treatment and fees for professional services rendered me will be immediately due and payable.
A photocopy of this assignment shall be considered as effective and valid as the original

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment to:
Absolute Foot care P.C

543 Hempstead Turnpike
West Hempstead NY 11552

**Patient Signature:_____ Date:_____**
**Guardian Signature:_____ Date:_____**

## HIPAA Privacy Notice Acknowledgement

I, _____ acknowledge that I have been provided with a copy of Absolute Foot care P.C privacy notice. I would like to authorize the following to have access to my protected health information.

**Signature:_____ Date:_____**

**ASSURANCE OF PRIVACY FOR OUR PATIENTS**

To Our Valued Patients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rules". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine an appropriate use of PHI in accordance with the governmental rules laws and regulations. We want to assure that out practice never contributes in any way to the growing problem of improper disclosure on PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy and integrity. More so, we welcome your input regarding any service problem that we may remedy the situation promptly.

**NOTICE OF PRIVACY**

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry our treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with your HIPPA Compliance Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name _____ ____

Signature _____ Date _____

If minor, signature of parent or guardian _____