

NEW PATIENT INFORMATION

Please fill out completely

TODAYS DATE: _____ E-MAIL ADDRESS: _____

Patients Full Name:

Last: _____ First: _____ MI: _____ Sex: M
F

Patients SS# _____ Date of Birth: _____ DL# _____

Marital Status S M D W Name of Spouse: _____

Phone: _____ Work: _____ Cell: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Second or out of State Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Name: _____ Pharmacy #: _____

Employer Name: _____ Job Title: _____

Company Phone: _____ Address: _____

How did you hear about us: _____ If referred, by whom: _____

Name and relationship of Emergency Contact: _____

Phone Number of Emergency Contact: _____

Name of Family Physician: _____ Date Last Seen: _____

Phone: _____ Fax: _____

SIGNATURE OF RESPONSIBLE PARTY DATE _____

Person responsible for services rendered if different than listed above:

Name: _____ SS#: _____

Address: _____

Phone: _____

1. Please describe your medical problem and what brings you to the office today:

2. How would you describe your pain: Sharp Aching Throbbing Burning Shooting
Shooting Electrical Sensation Pins and Needles

3. Location of pain or primary complaint: Lower Leg Ankle Achilles Tendon Heel Midfoot
Arch Forefoot Sole of Foot Ball of Foot Top of Foot Big Toe Lesser Toes Toenails

5. How long has your problems been present: 1 – 3 days 3 – 7 days 1 – 3 weeks 3
– 6 weeks
6 – 8 weeks 3 – 6 months 6 – 9 months 9 – 12 months Greater than 1 year

6. Onset of condition or injury: Gradual onset over time Sudden onset from activity or injury

7. Course/Progression of Condition: Severe Worsening Moderate Worsening Mild Worsening
Steady/Unchanging Mild Improvement Moderate Improvement Considerable/Good Improvement

8. Pain/Condition Aggravated by: Any Weight Bearing Standing Walking Running Exercise
Bending Stooping Pressure to Ball of Foot Pressure from Shoes Pressure from
Jumping

9. Have you attempted any treatments to relieve your problem: Rest Ice Elevation Change shoe gear
OTC padding "over the counter" OTC anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)
In home whirlpool Stretching Trimming out toenail yourself Applying skin cream applying topical antibiotic

11. How much improvement and relief have you achieved with previous treatment: Mild Improvement
Moderate Improvement Considerable Improvement No Improvement Worsening of Condition

12. Pain worse on 1st morning walking/activity Pain worse when standing & walking after rest Pain worse in shoes
Pain worse with any movement Pain worse after running/exercise Pain worse after working on ladder
Pain decreases after 1st 15-20 minutes of walking Pain decreases after rest Pain decreases after removing shoe
Pain decreases after rubbing area Pain decreases after trimming out toenail, but returns in several days

13. What is your activity level at work: Sitting Standing Walking Considerable movement/walking Retired

14. Name of Primary Care/Family Physician (First and Last Name) _____

15. Date Last Seen By Primary Care/Family Physician(Month, Day and Year) _____

16. How did you hear about our office: Physician Family/Friend Internet News paper Phone Book
Advertisement Other _____

19. Past Medical History: Hypertention/High Blood Pressure HIV/AIDS Hepatitis Heart Attack/MI
Insulin Dependent Diabetes Non Insulin Dependent Diabetes Stroke/CVA Aneurysm Blood Clot

20. Respiratory: Asthma Emphysema Tuberculosis Lung cancer Collapsed lung/atelectasis
Bronchitis Shortness of breath Valley fever Pneumonia

23. Cardiovascular: Hypertension/high blood pressure Pacemaker Angina Open heart/bypass surgery
Myocardial Infarct/Heart attack Chest pain Angioplasty Palpitations/irregular beats

Valve prolapse/heart murmur Rheumatic fever

32. Vascular/Circulation: Circulation disorder/decrease Atherosclerosis/blocked arteries Blood clot/deep vein thrombosis
Leg pain at rest High cholesterol Varicose veins Leg pain with walking Phlebitis

41. Hematological - Have you been anticoagulant with any of the following blood thinners: (if so -please specify date)
Coumadin Heparin Aspirin Plavix Other Blood Thinner/Anticoagulant medications

43. Endocrine - Do you have: Diabetes Thyroid Disease

48. Neurological: Seizures Stroke Neuro-muscular disease Change in memory Numbness
Polio Tremor Sciatica Frequent head aches Muscle weakness

51. Musculoskeletal: Arthritis/degenerative joint disease Gout Hip pain Frequent muscle/tendon/pain
Rheumatoid arthritis Back pain Knee pain

58. Musculoskeletal - Do you have any of the following joint replacements/prosthesis:
Hip Knee Ankle Hands Feet Spine

64. Date of replacement: _____

65. Integument: Skin rashes Psoriasis Eczema Color change to mole or wart Skin cancer
Skin growth Itching to skin Thick scar/keloid Change in size of skin growth Hives

66. Immunology - Do you have: HIV Frequent infections/weak immune system Chronic fatigue syndrome/Ebstein Barr

67. Past medical History – Injuries/Trauma _____

68. Have you had any of the following foot surgeries: Toenail Hammertoe Fracture repair
Joint fusions Tendon repair/rerouting Ankle stabilization Arthroscopy Bunion

70. Please list approximate month and year of any surgery listed above: _____

78. Past Surgical History: Have you had any of the following surgeries:
Heart bypass Heart valve repair/replacement Appendectomy Gallbladder Brain surgery Other

79. Please list approximate month and year of any surgery listed above: _____

85. Any other surgeries (Please specify type of surgery and date) _____

86. Any complications/problems with surgery or anesthetics (Please specify) _____

87. Previous hospitalization - have you been admitted for: Heart attack Stroke Pneumonia
Cancer Infection Injury Other hospitalizations _____

88. Please list approximate month and year of any hospitalization listed above: _____

95. Childhood History: Rheumatic Fever Measles Mumps Chickenpox Herpes/cold sores

96. Social History - Do you: Smoke Tobacco Smoke Marijuana Use hallucinogenic drugs
Drink Alcohol Use Cocaine Use other recreational drugs

98. Number of drinks per day? 1 2 3 4 5 Greater than 5 per day
Occasional use only Social drinking only Weekend drinking only

If you use other recreational drugs - please list/specify: _____

99. If you smoke, number of packs per day? 1/2 1 2 3 4 5 or more
Occasional use only Social smoking only Weekend smoking only

100. Women - Are you pregnant? Yes No 140. Number of Months: _____

102. Medications - please list medications (including aspirin) currently taking:

103. Allergies – Do you have allergies to any of the following: Drug Allergies Penicillin Sulpha Aspirin
Erythromycin Cortisone Codeine Adhesive Tape Local anesthetics no known allergies

104. Other allergies to medications – please list: _____

105. What is your height _____ What is your weight _____ What is your shoe size _____

NOTICE OF PRIVACY PRACTICES

Our Promise! ~ It is our desire to communicate to you that we are taking the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used. We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient. We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

To Provide Treatment ~ We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment ~ We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations ~ Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, Licensing or credentialing activities.

In Patient Reminders ~ Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

Abuse or Neglect ~ We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security ~ We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, with coroners, funeral directors and medical examiners for the purposes of determining a cause of death

Patient Right ~ This new law is careful to describe that you have the following rights related to your health information.

Restriction ~ You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications ~ You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information ~ You have the right to read, review, and copy your health information, including your complete chart, w-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information ~ You have the right to ask us to update or modify your records if you believe your health information records

are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provided us with your request in writing and describe your reason for the charge. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information ~ You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice ~ You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgment

Patient Name

Patient Signature

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

INSURANCE INFORMATION

Please fill out this portion.

PRIMARY INSURANCE:

Medicare Yes No MEDICARE #: _____

Insurance Name _____

ID# _____ GRP# _____

Plan # _____

Co-pay Yes No AMOUNT \$ _____

SECONDARY INSURANCE:

Medicare Yes No MEDICARE #: _____

Name of Insurance _____

ID# _____ GRP# _____

Plan# _____

ASSIGNMENT AND RELEASE:

Primary / Secondary Insurance

I, the undersigned have _____ insurance, and assign directly to Dr. Feldman/Dr. Kelman, D.P.M. all medical benefits, if any, otherwise payable to me for any 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 information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance

submissions.

SIGNATURE OF INSURED / GUARDIAN

DATE

MEDICARE AUTHORIZATION

Primary / Secondary Insurance

I request that payment of authorized Medicare benefits be made to Dr. Feldman/Dr. Kelman, D.P.M. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the DEDUCTIBLE, COINSURANCE, and NONCOVERED SERVICES. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE OF INSURED / GUARDIAN

DATE