FOOT & ANKLE SPECIALISTS OF THE TWIN TIERS, PC

455 MAPLE STREET, SUITE 2
BIG FLATS, N.Y. 14814

Phone: 607-562-7300
Fax: 607-562-7575

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

MAILING ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

ALTERNATE PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

HOW DID YOU HEAR ABOUT US: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ NO _____ YES NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

SUBSCRIBER NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

SUBSCRIBER ID # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

SUBSCRIBER NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

SUBSCRIBER ID # _____ GROUP # _____

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____
_____ _____
_____ _____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ **OCCUPATION**: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

WHO DO YOU LIVE WITH? ☐ SPOUSE ☐ PARTNER – NAME_____ ☐ CHILDREN–AGE(S) _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY:

	DIABETES	CANCER	HEART DISEASE	STROKE	BLOOD CLOTS	HIGH BLOOD PRESSURE	RHEUMATOID ARTHRITIS	OTHER:
MOTHER								
FATHER								
OTHER								

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

A-FIB (ATRIAL FIBRILLATION)	Y	N		DIABETES	Y	N		MITRAL VALVE PROLAPSE	Y	N
ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		OTHER MENTAL HEALTH CONDITION:_____	Y	N
ANXIETY/DEPRESSION	Y	N		HEARING LOSS	Y	N		PARKINSON'S DISEASE	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		RHEUMATOID ARTHRITIS	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		SEIZURES	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		SICKLE CELL DISEASE	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SKIN DISORDER TYPE:_____	Y	N
ABNORMAL BLEEDING	Y	N		HIGH BLOOD PRESSURE	Y	N		SLEEP APNEA	Y	N
BLOOD CLOTS	Y	N		HIGH CHOLESTEROL	Y	N		STOMACH ULCERS	Y	N
BLOOD TRANSFUSION	Y	N		KIDNEY DISEASE	Y	N		STROKE	Y	N
BRONCHITIS/EMPHYSEMA	Y	N		LIVER DISEASE	Y	N		THYROID DISEASE	Y	N
CANCER (LOCATION:_____)	Y	N		MIGRAINE HEADACHES	Y	N		TUBERCULOSIS	Y	N

OTHER CONDITIONS:

Describe any recent or ongoing symptoms with your general health:

Constitutional: Fever, chills, unexplained weight change, unexplained falls?_____
Head, Eyes, Ears, Nose, Throat: Difficulty hearing, seeing, nosebleeds, difficulty swallowing?_____
Cardiovascular: Chest pain, leg swelling, irregular heartbeat, pain in calf while walking?_____
Respiratory: Shortness of breath, cough, wheeze?_____
Neurologic: Dizziness, numbness, tingling, weakness, tremor?_____
Gastrointestinal: Heartburn, nausea, vomiting, diarrhea, stomach ulcer, blood in stool?_____
Genitourinary: Frequent urination, trouble urinating, blood in urine?_____
Musculoskeletal: Joint pain, joint swelling, joint redness, joint stiffness?_____
Skin: Dry skin, wounds, itching, rash, foot/ankle ulcer?_____
Hematologic: Prolonged or excessive bleeding, easy bruising? _____
Endocrine: Frequent hunger, frequent thirst, heat or cold intolerance? _____
Other symptoms? _____

What types of shoes do you most often use?_____
What is your Height _____ Weight _____ Shoe size _____?
Any other health concerns that your doctor may need to know?
_____

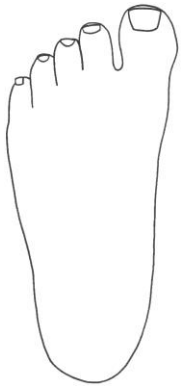
PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

CURRENT PROBLEM

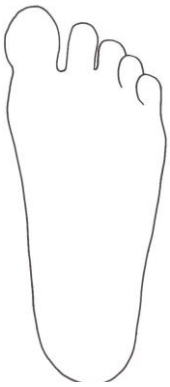
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

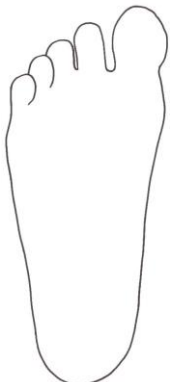


BOTTOM OF FOOT

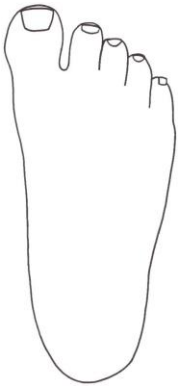
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

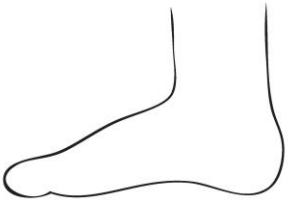


BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED ALL OF THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT MEDICAL INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

Foot and Ankle Specialists of the Twin Tiers, P.C.

I, the undersigned certify that I (or my Dependent) have insurance coverage with _____ _____ and assign directly to Foot and Ankle Specialists of the Twin Tiers, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Foot and Ankle Specialists of the Twin Tiers, P.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Patient or Responsible Party Signature Date

Although we make every attempt to be thorough with the information given at the time of scheduling appointments, it has come to our attention that some insurance companies have various plans that we may not be a part of. Ultimately it is your responsibility to check with your insurance company to see if we are IN NETWORK or if referrals are needed from your primary care physician.

_____
Patient or Responsible Party Initials Date

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

Foot and Ankle Specialists of the Twin Tiers, P.C.
455 Maple Street, Suite 2
Big Flats, N.Y. 14814

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that the U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Please contact us at 607-562-7300 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the treatment rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example, our accountant may see your name, dates of treatment, and procedure codes during audits of our books. Similarly, we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where: 1.required by law 2. Required for public health purposes 3. Required by law to report child abuse 4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct 5. Required by law in judicial or administrative proceedings 6. Required for law enforcement purposes by a law enforcement official 7. Required by a coroner or medical examiner 8. Permitted by law to a funeral director 9. Permitted by law for organ donation purposes 10. Permitted by law to avert a serious threat to health or safety 11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States 12. Research purposes 13. Required by medical concerns, to release to family members or close friends who are involved in your health care.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence or your place of business, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided on the reverse side of this page.

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Privacy Rights that you have.

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR $ 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities, or law enforcement officials as permitted by law, or for research or public health purposes after being de-identified or limited to remove personally identifiable information or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Foot and Ankle Specialists of the Twin Tiers P.C., confidential, 455 Maple Street, Suite 2, Big Flats, NY, 14814.

No retaliatory action will be taken against you for any complaint you may make.

I have received a copy of this notice, I have read or had the opportunity to read it, and understood it.

_____ _____

Signature Date

_____ _____

Print Name Patient Name (if other than person signing)

I make the following special request for confidential communications:

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

The following person(s) are permitted to have access to my medical/appointment information. I may revoke this at any time.

1) Name:_____ Relationship:_____ Medical information
Appointment information
(Please circle one/both)

2) Name:_____ Relationship:_____ Medical information
Appointment information
(Please circle one/both)

3) Name:_____ Relationship:_____ Medical information
Appointment information
(Please circle one/both)

4) Name:_____ Relationship:_____ Medical information
Appointment information
(Please circle one/both)

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PATIENT'S MEDICARE AUTHORIZATION

Patient's Name_____ Patient's Medicare #:_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to:
FOOT & ANKLE SPECIALISTS OF THE TWIN TIERS, P.C.
DR. CHAD BATZING/ DR. DEVIN HULL/ DR. GINA AMICATERRA

For any services furnished me by that physician/supplier. 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 to 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 the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of the Medicare carrier.

_____ _____
Patient's Signature Date