DRV FOOTCARE P.C
1027 liberty Ave
Brooklyn NY 11208
718-348-5981

Name_____
Date_____

Medication List

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____

I Authorize Pharmacy and doctors office to fax my medication list to the office of DR. Tamira VanNOY if the patient does not know the names of the medications.

_____
Signature

FIRST CHOICE DIAGNOSTICS

Patient Questionnaire
NCV Indications

Please circle *YES* or *NO* to the following questions. This will aid us in completing your medical history.

1. Do you suffer from neck pain, with pain in your arms or hands?.....YES NO
2. Do you have weakness, numbness, or burning in either your arms or your hands?.....YES NO
3. Do your hands or arms fall asleep?.....YES NO
4. Do you have reduced feeling (sensation) in your hands or arms?.....YES NO
5. Do you suffer from a loss of hand grip strength?.....YES NO
6. Do you suffer from back pain with pain in your buttocks, legs, or feet?.....YES NO
7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet?.....YES NO
8. Do your legs or feet fall asleep?.....YES NO
9. Do you have reduced feeling (sensation) in your buttocks, legs, or feet?.....YES NO

Patient Signature _____ Date

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

ACKNOWELEDGMENT 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) and understood the Notice.

X _____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

X _____

Signature

Tamira Van Noy, DPM

Triple i / CliniForms

Patient Registration

Name _____ SS# _____

General Medical Information

Describe the current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑ Yes ❑ No

Do you smoke? ❑ No ❑ Yes ❑ Cigarettes ❑ Pipe ❑ Cigars No. of years _____ How much? _____

Interested in stopping? ❑ Yes ❑ No

Do you regularly drink alcohol? ❑ Yes ❑ No How many ounces/beers per day? _____

Do you regularly drink coffee? ❑ Yes ❑ No How many cups per day? _____

Are you under a lot of pressure at work? ❑ Yes ❑ No Please describe: _____

Personal Medical History

Have you ever had any of the following (check all that apply):

❑ Chest pain/pressure/tightening _____	❑ Asthma _____	❑ Kidney disease _____
❑ Hypertension _____	❑ Dizzy spells _____	❑ Shortness of breath _____
❑ Heart attack _____	❑ Cancer _____	❑ TB/Lung disorder _____
❑ Stroke _____	❑ Diabetes _____	❑ Ulcers _____
❑ Headaches _____	❑ Arthritis _____	❑ Skin disorders _____
❑ Glaucoma _____	❑ Difficulty hearing _____	❑ Hepatitis _____
❑ Allergies or Eczema _____	❑ Glaucoma _____	❑ Cataracts _____
❑ Depression _____	❑ Memory loss _____	❑ Digestive problems _____
❑ Blood in stool _____	❑ Hemorrhoids _____	❑ Frequent urinary infections _____

❑ Other: _____

Immunizations

(Year last received, if known)

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

Rubella _____

Hepatitis _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Eczema / Psoriasis	❑	❑	❑	❑	❑	❑
Heart attack / Stroke	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Hay fever	❑	❑	❑	❑	❑	❑

Name

Tamira Van Noy, DPM

Triple i / CliniForms

Patient Registration

Name _____ SS# _____

Street Address _____ Date of birth _____ Marital status: S M W Sep D

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Referred by _____

Spouse's name _____

Spouse's employer / address _____

Emergency contact _____ Tel# _____ Relationship _____

Patient Employer Information

Employer name _____ Tel# _____

Employer street address _____ City / State _____ Zip _____

Patients occupation _____

Insured Person (if not patient)

Name _____ Tel# _____

Street Address _____ City / State _____ Zip _____

Relationship to patient _____

Insurance

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

Secondary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(Patient, parent, or guardian)

Name