WELCOME TO OUR OFFICE!

Date ______________________

PATIENT INFORMATION

Name ______________________

Nickname ______________ Sex: Male / Female

Birth Date ______________ Age ________

Marital Status:
Single / Married / Divorced / Widowed

Social Security # ______________________

Address ______________________

City / State ______________ Zip ________

Home Phone ______________________

Work Phone ______________________

Best Time / Place to call ______________

Email ______________________

Occupation ______________________

Employer ______________________

Address ______________________

City / State ______________ Zip ________

Employer Phone ______________________

How did you hear about our office?

Yellow Pages / Website / Family
Friend / Physician / Insurance Plan

Other: ______________________

We would like to thank them!

Name ______________________

Address ______________________

City / State ______________ Zip ________

INSURANCE

Insured Name ______________________

Relationship to Patient ______________________

Insured Birth Date ______________________

Is this patient covered by additional insurance?
YES **NO**

MEDICATIONS

List all medications you are currently taking including over-the-counter products, vitamins, and herbals.

____

____

____

____

Pharmacy Name ______________________

ALLERGIES

Have you ever experienced any **ALLERGIES** or **ADVERSE EFFECTS** to any of the following?

	YES	NO
Adhesives / Tape	☐	☐
Aspirin	☐	☐
Anti-Inflammatories	☐	☐
Codeine	☐	☐
Iodine (IVP dye)	☐	☐
Local Anesthetics (Novocaine / Lidocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐

OTHER: ______________________

____

MEDICAL HISTORY

Please check "YES" or "NO" to indicate if you have had any of the following:

	YES	NO		YES	NO
AIDS / HIV	❑	❑	Hepatitis	❑	❑
Arthritis	❑	❑	High Blood Pressure	❑	❑
Asthma	❑	❑	High Cholesterol	❑	❑
Back Problems	❑	❑	Kidney Problems	❑	❑
Blood Clots	❑	❑	Liver Problems	❑	❑
Cancer	❑	❑	Parkinson's Disease	❑	❑
Diabetes	❑	❑	Psychiatric Problems	❑	❑
Epilepsy	❑	❑	Stomach Ulcers	❑	❑
Eye Problems	❑	❑	Stroke	❑	❑
Foot / Leg Cramps	❑	❑	Thyroid Problems	❑	❑
Gout	❑	❑	Are you a smoker?	❑	❑

OTHER: ____

Please **list all surgeries** and approximate dates ______________________________

____

____

DIABETICS: Please answer the following questions:

How many years have you been diagnosed as a diabetic? ______________________

Blood Sugar Checks: How many times each day? __________ Average reading? __________

FOOT HEALTH INFORMATION

What is your current foot problem? ______________________________

When did it begin? ______________________________

How have you treated this problem so far? ______________________________

Have you seen another doctor for this problem? __________ If so, whom? ______________

Have you ever seen a foot doctor? __________ If so, whom? ______________

Shoe size __________ Height __________ Weight __________

Who is your **Primary Care Physician**? ______________________ Date of Last Visit __________

Physician's Address ______________________ Phone: ______________

Are you under regular care for any specific problem? ______________________

In case of emergency, contact Name: ______________________ Phone: ______________

NORTH ROCKLAND PODIATRY

Peter Costa, D.P.M., F.A.C.F.A.S.

7 Liberty Square
Stony Point, NY 10980
Telephone: 845.429.0520//Fax: 845.429.0603

ACKNOWLEDGEMENT 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.

______________________________ Date ______________________

Patient Name (please print)

____

Parent or Authorized Representative (if applicable)

____

Signature

Who else can receive results or any other information for above patient?:

Name:	Phone Number:
1.	
2.	
3.	

North Rockland Podiatry
Peter Costa, D.P.M., F.A.C.F.A.S
7 Liberty Square Mall
Stony Point, NY 10980
Phone: 845-429-0520

Our Office Policies:

- ☐ All copays are due at time services are rendered. If you cannot pay your co-pay at the time of the visit, please talk to the receptionist before being seen by the doctor. We accept cash, check, Visa, MasterCard and Discover. Please make all checks payable to: **NORTH ROCKLAND PODIATRY, P.C.**

- ☐ For *all* **follow up** visits **you will be charged a copay** (if required by your insurance company). This includes orthotic dispensing/orthotic checks and post-operative visits.

- ☐ If you have Insurance we do not participate with or you have no Insurance coverage, payment is due at the time of service.

- ☐ If your Insurance plan requires a referral, you must present it at the time of your visit. **It is the patient's responsibility to get referrals if they are needed.** If you come to your appointment without a valid referral YOU will either be rescheduled or charged for the visit.

- ☐ If you do not inform us of any special requirements with your contract and we order services (lab work, x-rays, etc.) and these services are not covered our office will bill the patient.

- ☐ Any fees or services provided during a period where your coverage is not in effect, all fees submitted and denied will be the patient's responsibility.

- ☐ Appointments that are missed without any notification will have a charge of $25.00 placed on account. A Charge of $75.00 will be placed on account for a missed in-office surgical procedure. A charge of $20.00 will be placed on account for returned checks.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND I AGREE TO ACCEPT PERSONAL RESPONSIBILITY AS DESCRIBED.

Signature:______________________________ **Date:**________________