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 ____________________

Cell Phone ____________________

Best Time / Place to call ____________________

Email ____________________

Occupation ____________________

Employer ____________________

Address ____________________

City / State ____________ Zip ________

Employer Phone ____________________

How did you hear about our office?

/ 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: ____________________

____

Past Surgeries

____

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

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

RIGHT FOOT

BOTTOM OF FOOT

TOP OF FOOT

Height: _______

Weight _______

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/______

INSIDE OF FOOT	OUTSIDE 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

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT 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

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:**_______________