### WELCOME TO OUR OFFICE!

INSURANCE		
Insured Name		
1		
Is this patient covered by	additional ir	
List all medications you are currently taking including over-the-counter products, vitamins, and herbals		taking itamins,
Dhama		
Pnarmacy Name		
ALLERGIES		
Have you ever experienced ADVERSE EFFECTS to	any ALLE	RGIES or
	ally of the fo	llowing?
Adhesives / Tape Aspirin Anti-Inflammatories	YES	NO □
Codeine	]	
Local Anesthetics		
(Novocaine / Lidocaine) Penicillin	000	000
	_	
	Insured Name	Insured Name

NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

TINVE TOO STER HAD ANTI	UF : 1	3 E E 1
ACID REFLUX	Y	N
Anemia	Y	N
ARTHRITIS	Y	N
ASTHMA	Y	N
BACK TROUBLE	Y	N
BLADDER INFECTIONS	Į Y	N
ABNORMAL BLEEDING	Y	N
BLOOD CLOTS	Υ	N
BLOOD TRANSFUSION	Y	N
BRONCHITIS/EMPHYSEMA	Y	N
CANCER	Y	N
DIABETES: TYPE 1 OR	Y	N
TYPE 2 (CIRCLE)	i	
OTHER CONDITIONS:		

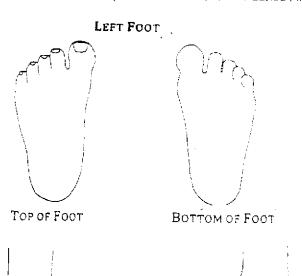
FIBROMYALGIA	$\overline{Y}$	N
Gout	Y	N
HEART ATTACK	Y	N
HEART DISEASE/FAILURE	Y	N
HEPATITIS	Ϋ́	N
HIV+/AIDS	Y	N
HIGH BLOOD PRESSURE	Y	ν!
KIDNEY DISEASE	У	N
LIVER DISEASE	Y	N
Low Blood Pressure	Y	N
MIGRAINE HEADACHES	V	N
MITRAL VALVE PROLAFSE		N

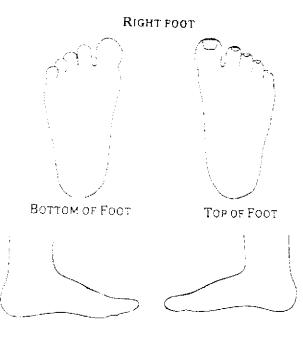
NEUROPATHY	Y	N
OPEN SORES	Y	N
PNEUMONIA	Y	N
Polio	Y	N
RHEUMATIC FEVER	ŧγ	N
SICKLE CELL DISEASE	Y	N
SKIN DISORDER	Y	N
SLEEP APNEA	Ţ	N
STOMACH ULCERS	Y	N
STROKE	ΙΥ	N
THYROID DISEASE	Y	N
TUBERCULOSIS	Ý	N
		<u> </u>

#### CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

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





Height: \_\_\_\_\_ Weight \_\_\_\_

PATIENT NAME:		* Nobel William Brailings	
INSIDE OF FOOT	OUTSIDE OF FOOT	OUTSIDE OF FOOT	Inside of foot
:			
:		Days / Weeks / Months /	
DID YOUR PAIN OR PRO	BLEM: BEGIN ALL OF A SUDDE	GRADUALLY DEVELOP O	VER TIME
How would you des	CRIBE YOUR PAIN? NO PAIN	SHARP DULL ACHING OTHER	☐ BURNING
HOW WOULD YOU RAT	E YOUR PAIN ON A SCALE FROM 0 T 1 2 3 4 5 6	TO 10? (PLEASE CIRCLE) 7 8 9 10 (WORST P	AIN POSSIBLE)
SINCE THE TIME YOUR	PAIN OR PROBLEM BEGAN, HAS IT:	STAYED THE SAME BECOME V	VORSE MPROVED
RESTING [	DRESS SHOES HIGH HEELS	Walking □ Standing □ Dail □ Flat shoes □ Any closed t	OF SHOF
WHAT MAKES YOUR PA	ain or problem feel better?		
		######################################	
		ABILITY TO WORK?	
WAS THIS PROBLEM C	AUSED BY AN INJURY? YES (DES	CRIBE)	
•	A WORK-RELATED INJURY?		
·	•		
THAT PROVIDING INCO	RRECT INFORMATION CAN BE DANG	EQUESTIONS ON THIS FORM ACCURATI GEROUS TO MY HEALTH. I UNDERSTAN AFF OF ANY CHANGES IN MY MEDICAL S	D THAT IT IS MY
PRINT NAME OF PATI	ENT, PARENT OR GUARDIAN	Signature of D	OCTOR
IF OTHER THAN PATIE	NT, RELATIONSHIP TO PATIENT	DATE	
Sig	NATURE		
D	ATE		
	•		
Revised June 2015			

### 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.

Patient Name (please print)	Date
Parent or Authorized Representative (if applic	cable)
Signature	
Who else can receive results or any	y 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:

Sign	ature:Date:
I H. ABC	AVE READ AND UNDERSTAND THE OFFICE POLICIES STATED OVE AND I AGREE TO ACCEPT PERSONAL RESPONSIBILITY AS DESCRIBED.
О	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.
	Any fees or services provided during a period where your coverage is not in effect, all fees submitted and denied will be the <u>patient's responsibility</u> .
	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.
0	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 have Insurance we do not participate with or you have no Insurance coverage, payment is due at the time of service.
O	For <u>all</u> <b>follow up</b> visits <b>you will be charged a copay</b> (if required by your insurance company). Th includes orthotic dispensing/orthotic checks and post-operative visits.
	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.