Practice: Lance Berlin, DPM Today's Date:

Name: _____ **DOB**: _____ **Chart Number:** _____

Sex: ☐ M ☐ F **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#**_____

E-Mail: _____ **Spouse/Partner Name:** _____

Address: _____ **City**:_____ **State:** _____ **Zip**:_____

Home #: _____ **Cell #:**_____ **Work #:**_____

Whom may we contact in the case of an emergency? _____ **Phone:** _____

Pharmacy: _____ **Address:** _____**Phone:**_____

Employer: _____ **Phone:** _____

Address: _____

Primary Insurance: _____ Are you the insured: ☐Yes ☐ No

Insured Information

Subscriber Name: _____Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/_____

Address: _____

Policy ID: _____ Group ID: _____

Secondary Insurance: _____ Are you the insured: ☐Yes ☐ No

Insured Information

Subscriber Name: _____Relationship to insured: ☐Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/_____

Address: _____

Policy ID: _____ Group ID: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone Book ☐ Family Member ☐ Friend ☐ Other

Who may we thank? _____

What is the reason for your visit today? _____

_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (0 being no pain and 10 being the worst) what is your level of pain? ____/10

The pain quality is ☐ burning ☐constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling other: _____

Please read and sign

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

_____ *(patient signature)* *Date:* _____

Revised 01/01/2016

History and Physical

Name:_____ **DOB:** _____ **Chart Number:** _____

Medical History: ☐ Alcoholism ☐ Blood Disorders ☐ Circulation Problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep Apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood Clot ☐ High Cholesterol ☐ High blood pressure ☐ Diabetes (type I or II)
☐ Neuropathy (specify) _____ ☐ Thyroid disease (specify) _____ ☐ Skin disorder (specify) _____
☐ Arthritis (specify) _____ ☐ Other (specify) _____
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Surgical History: ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any artificial joints ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve ☐ Yes ☐ No

Social History: Do you smoke**:** ☐ Yes ☐ No If yes how many packs per day? _____ For how long? _____
Do you drink alcohol? ☐ Yes, everyday (5-7 days per week) ☐ Yes, occasionally/socially ☐ No/ Rarely
Substance Abuse: ☐ Yes, I have a current substance abuse problem. Specify: _____
☐ Yes, I have had a previous substance abuse problem. Specify: _____
☐ No, I have never had a substance abuse problem.
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly ☐ Yes; I do the following regular exercise: _____
☐ No, I do not exercise regularly

Family History Is there any family history (blood relative) of:

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes (type I or II)	_____
☐ Bleeding Disorders	_____	☐ Emphysema	_____
☐ Blood Clot	_____	☐ Heart Disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____	***(please indicate family member)***	

Review of Systems *(Please check the box if you currently have any of these symptoms)*

Cardiovascular ☐ leg pain when walking ☐ fever ☐ chest pain/ pressure ☐ leg swelling ☐ cold hands/feet ☐ fainting ☐ palpitations ☐ vascular disease ☐ valve problems ☐ None

Genitourinary ☐ blood in urine ☐ hesitancy ☐ incontinence ☐ increase urgency ☐ decrease frequency ☐ excessive urination ☐ kidney disease ☐ kidney stones ☐ None

Gastrointestinal ☐ abdominal pain ☐ heartburn ☐ blood in stool ☐ vomiting ☐ ulcers ☐ diarrhea ☐ trouble swallowing ☐ constipation ☐ increase appetite ☐ decrease appetite ☐ None

Integumentary ☐ athlete's foot ☐ nail abnormalities ☐ keloids ☐ itchiness ☐ dry, scaly skin ☐ None

Hematologic ☐ lower leg ulcers ☐ sickle cell disease ☐ anemia ☐ blood thinners ☐ clotting disorder ☐ None

Neurological ☐ tingling ☐ tremors ☐ weakness ☐ seizures ☐ numbness ☐ headaches ☐ paralysis ☐ None

Musculoskeletal ☐ back pain ☐ joint swelling ☐ muscle weakness ☐ muscle pain ☐ neck pain ☐ sciatica ☐ joint stiffness ☐ joint pain ☐ joint instability ☐ arthritis ☐ None

Respiratory ☐ chest pain ☐ wheezing ☐ COPD ☐ coughing ☐ snoring ☐ shortness of breath ☐ emphysema ☐ None

Please read and sign

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_____*(patient signature)* *Date:* _____

Revised 01/01/2016

Name: _____ **Chart**: _____ **Date of Birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ Declined to Specify

Race: ☐White ☐Asian ☐American Indian or Alaska Native ☐ White ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ Declined to Specify

Preferred Language: _____
Primary Care Physician: _____ **Phone:** _____

Privacy Information Preferences:

Can we send mail to the address on file? ☐ Yes ☐ No Can we call the phone number on file? ☐ Yes ☐ No

Can we leave voicemail on answering machine? ☐ Yes ☐ No

Will you allow internet based delivery reminders like email? ☐ Yes ☐ No
If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: _____
Names: _____

Smoking Status

☐ Current Every Day Smoker ☐ Smoker, current status unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown if Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs (please fill in your last known)

Blood Pressure: _____/_____
OR CIRCLE: NORMAL HIGH LOW

Height: _____Weight: _____

Current Medications ☐ None

If you have a list we can make a copy

Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____
Name: _____ Dose_____

Use the back of this form if more room is needed

Allergies

Allergies	Reaction
☐ No Known Allergies	☐ No Known Drug Allergies
☐ Penicillin	_____
☐ Shellfish	_____
☐ Sulfa	_____
☐ Tape	_____
☐ Latex	_____
☐ Betadine (Iodine)	_____
☐ Aspirin	_____
☐ Tylenol™	_____
☐ Ibuprofen	_____
☐ Codeine	_____
☐ Other (specify)_____	

_____
_____

Last Flu Shot Date: _____ Did you get a pneumococcal vaccination? ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐Yes ☐ No Were you injured from the fall? ☐ Yes ☐ No

Have you completed any Advanced Directives? ☐ Yes ☐ No

Please read and sign

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_____*(patient signature)* *Date:* _____

Revised 01/01/2016

LANCE BERLIN, D.P.M., P.C. Podiatric Medicine and Surgery
Union Medical Plaza, 2330 Union Boulevard, Islip, NY 11751
Phone: 631-277-8900 Fax: 631-277-0298 Web: www.lanceberlin.com

NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I have received and reviewed, or have been offered and declined Lance Berlin, D.P.M, P.C. notice of privacy practices. Should I have any questions regarding the notice of privacy practices, I understand that I can contact this office at 631-277-8900.

Release of Medical Information

I hereby authorize Lance Berlin, D.P.M. to release any medical information necessary to process claims. I hereby assign to the physician all payments for medical services for any amount not covered by insurance.

Claim Authorization – Medicare

I request that payment of authorized Medicare benefits be made to the treating physician for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the health care financing administration, and its agents, any information needed to determine the benefits payable to related services.

In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Authorization for Other Carriers

I hereby authorize my physician health care practitioner, hospital, or any other medically related facility to furnish any and all records, medical, history, and services rendered or treatment given to me for purposes of review or evaluation of any claim submitted.

I also authorize disclosure to a hospital or health care service plan any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a group contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of the utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term coverage, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, heirs, and executors.

Payment

Medicare will only pay for the services that it deems reasonable and necessary under section 1862 (a) (1) of the medical bylaw. By signing below; if Medicare denies payment, you agree to be personally responsible for payment.

PATIENT'S SIGNATURE: _____ DATE: _____

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NOTICE TO OUR PATIENTS

Although we participate in many insurance plans, it is impossible for our office to know the rules and regulations of each plan.

It is your responsibility to know the limits and requirements of your particular plan. (This includes necessity for referrals, covered and non-covered services, etc.) If you do not understand your coverage, we suggest you contact your insurance company.

Payment, including co-pay, is expected at the time of your visit. (Please note there will be a $25 charge for all returned checks.)

The daily schedule is well planned so that we may accommodate all our patients' needs. If you are unable to keep your scheduled appointment we ask that you inform the office at least 24 hours in advance. **There will be a $30 fee for missed appointments.**

I authorize the office of Dr. Lance Berlin to release to my health insurer, and its agents, the information that is essential for the determination of benefits payable for related services. I authorize the payment of insurance benefits to be made on my behalf to this office. **If I have no insurance or this office does not participate with my insurance, I understand that I am responsible for payment in full at the time of my office visit.**

I have read and understand the preceding information.

SIGNATURE_____ **DATE:**_____

****Beginning October 1, 2014 we have implemented the Patient Portal.****

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information such as: Recent doctor visits, Discharge summaries, Medications, Immunizations, Allergies, and Lab results.

If you would like to sign up for the Patient Portal please give us your email address and ask the front desk to print out the Patient Portal Instructions for you with your authoriztion code (expires in 4 days). Please be advised and remember your PIN # is your year of birth and **will not** be included on the sheet you will receive.

Email Address: _____