Lance Berlin, D.P.M., P.C. **Today's Date: ___/___/____**

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

Ethnicity: (circle one) Hispanic or Latino / Not Hispanic or Latino

Race: **(circle one)** White / American Indian / Asian / Black or African / Native Hawaiian

Did your address change?? Yes No *if yes, please write new address below

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

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

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

Primary Care Physician: _____ **Phone:** _____

Did your insurance change?? Yes No *if yes, please write new insurance information below. Indicate if it's your 1st, 2nd or 3rd insurance.

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: _____

Smoking Status:

☐ Current Every Day Smoker

☐ Current Some Day Smoker

☐ Former Smoker

☐ Never Smoker

Vital Signs (Please fill in your last known)

Blood Pressure: _____/_____ **or circle: High / Normal / Low**

Height: _____

Weight: _____

Privacy Information Preferences:

Would you like to see the HIPPA Privacy Practice Notice? ☐ Yes ☐ No

Were you offered a copy of the HIPAA Privacy Practice Notice? ☐ Yes ☐ No

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

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

Please turn to page 2 →

Lance Berlin, D.P.M., P.C. **Today's Date: ___/___/____**

Pharmacy: _____ **Town:** _____ **Phone #:** _____

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_____

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

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 1, type 2)
☐ Neuropathy (specify) _____ ☐ Thyroid disease (specify) _____ ☐ Skin disorder (specify) _____
☐ Arthritis (specify) _____ ☐ Other (specify) _____
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No
Flu shot received this flu season? ☐ Yes ☐ No **Pneumococcal Vaccination?** ☐ Yes ☐ No

Have you had any Falls within the last 12 months? ☐ Yes ☐ No

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

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding Disorders	_____	☐ Emphysema	_____
☐ Blood Clot	_____	☐ Heart Disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____	***(please indicate family member. Ex. Mom, Dad)***	

Please turn to page 3 →

Lance Berlin, D.P.M., P.C. **Today's Date: ___/___/____**

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: _____