

# AFFILIATED PODIATRISTS, LTD.



Drs. Harold Feder • Joel Feder • Marc Feder • Steven Miller • Ralph Esposito

## WELCOME TO OUR OFFICE

NAME \_\_\_\_\_  
LAST FIRST

ADDRESS \_\_\_\_\_  
STREET APT # CITY STATE ZIP

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ E-MAIL \_\_\_\_\_

AGE \_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

SEX (circle) M F HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

YOUR OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
NAME PHONE

MARITAL STATUS (circle) S M W D NAME OF SPOUSE \_\_\_\_\_

DO YOU HAVE HEALTH INSURANCE?  YES  NO *if yes, we'll need to copy your card(s).*

IS IT YOUR POLICY?  YES  NO WHOSE POLICY IS IT? \_\_\_\_\_

ARE YOU COVERED UNDER ANY OTHER ADDITIONAL HEALTH INSURANCE PLANS?  YES  NO

GUARANTOR (RESPONSIBLE PARTY FOR THIS ACCOUNT OR CUSTODIAL PARENT) *complete if different than above*

NAME \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ GUARANTOR'S SOCIAL SECURITY \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ GUARANTOR'S BIRTHDATE \_\_\_\_\_  
RELATIONSHIP PHONE

GUARANTOR'S EMPLOYER \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

NAME ADDRESS PHONE

• If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility.

**All unpaid balances and/or denied claims are your responsibility.**

NAME OF PRIMARY INSURANCE \_\_\_\_\_

NAME OF SECONDARY INSURANCE \_\_\_\_\_

NAME OF ADDITIONAL INSURANCE PLANS \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

PHYSICIAN'S HOSPITAL AFFILIATION \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

WHO REFERRED YOU TO OUR CARE? \_\_\_\_\_

● **WHAT IS YOUR FOOT PROBLEM?** \_\_\_\_\_

● **FOR HOW LONG HAVE YOU HAD THE PROBLEM?** \_\_\_\_\_ HAVE YOU BEEN TREATED FOR IT?  YES  NO

BY WHOM? \_\_\_\_\_

IS YOUR FOOT PROBLEM THE RESULT OF A WORK-RELATED INJURY?  YES  NO

# Medical Information

## Past Medical History

Have you ever had any of the following?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fevers over 103°    | <input type="checkbox"/> Prolonged Bleeding           |
| <input type="checkbox"/> Mumps           | <input type="checkbox"/> Balance Problems          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Psychological Problems       |
| <input type="checkbox"/> Chickenpox      | <input type="checkbox"/> Bladder Problems          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Blood/Plasma Transfusions | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Skin Problems                |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Bowel Problems            | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Hepatitis C         | <input type="checkbox"/> Swelling of Feet/Ankles      |
| <input type="checkbox"/> Smallpox        | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Digestion Problems        | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Disease              |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Ulcer                        |
| <input type="checkbox"/> AIDS or HIV+    | <input type="checkbox"/> Ear/Nose/Throat Problems  | <input type="checkbox"/> Numbness/Tingling   | <input type="checkbox"/> Varicose Veins               |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Vision Problems              |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Polio               | <input type="checkbox"/> Other _____                  |

Previous Hospitalizations/Surgeries/Serious Illness (and When?) \_\_\_\_\_

What medications &/or vitamins are you taking now and what dose? \_\_\_\_\_

(Women) Are you pregnant?  Yes  No      Are you taking Birth Control Pills?  Yes  No

Are you under the care of a physician?  Yes  No      If yes, for what reason(s)? \_\_\_\_\_

## Social History

Do you live alone?  Yes  No      For how long? \_\_\_\_\_

Do you have children?  Yes  No      If yes, how many? \_\_\_\_\_

Do you exercise?  Yes  No      If yes, how often? \_\_\_\_\_ What kind of exercise? \_\_\_\_\_

Are you on a special diet?  Yes  No      If yes, what kind? \_\_\_\_\_

Do you smoke?  Yes  No      If yes, how many packs per day? # \_\_\_\_\_ for # \_\_\_\_\_ years.

If no, when did you quit? \_\_\_\_\_ How many packs had you smoked? # \_\_\_\_\_ per day for # \_\_\_\_\_ years.

Do you drink alcohol?  Yes  No      How much \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Yearly

Do you have a history of substance abuse?  Yes  No      What substance(s)? \_\_\_\_\_

**Family History**

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Disease _____         | <input type="checkbox"/> Cancer _____       | <input type="checkbox"/> Diabetes _____      |
| <input type="checkbox"/> Circulatory Disease _____   | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Arthritis _____     |
| <input type="checkbox"/> Neurological Problems _____ | <input type="checkbox"/> Skin Disease _____ | <input type="checkbox"/> Foot Problems _____ |

Additional space, if necessary \_\_\_\_\_

**Review of Systems**

Please indicate any personal history below, circle:

- |   |   |   |
|---|---|---|
| <p>● <b>Constitutional Symptoms</b><br/>                 Good general health lately . . . . . No Yes<br/>                 Recent weight change . . . . . No Yes<br/>                 Fever . . . . . No Yes<br/>                 Fatigue . . . . . No Yes<br/>                 Headaches . . . . . No Yes</p> <p>● <b>Eyes</b><br/>                 Eye disease or injury . . . . . No Yes<br/>                 Wear glasses/contact lenses . . . . . No Yes<br/>                 Blurred or double vision . . . . . No Yes</p> <p>● <b>Ears/Nose/Mouth/Throat</b><br/>                 Hearing loss or ringing . . . . . No Yes<br/>                 Earaches or drainage . . . . . No Yes<br/>                 Sinus problem . . . . . No Yes<br/>                 Nose bleeds . . . . . No Yes<br/>                 Mouth sores . . . . . No Yes<br/>                 Bleeding gums . . . . . No Yes<br/>                 Bad breath or bad taste . . . . . No Yes<br/>                 Sore throat or voice change . . . . . No Yes<br/>                 Swollen glands in neck . . . . . No Yes</p> <p>● <b>Cardiovascular</b><br/>                 Heart trouble . . . . . No Yes<br/>                 Chest pain or angina . . . . . No Yes<br/>                 Palpitation . . . . . No Yes<br/>                 Shortness of breath w/exertion . . . . . No Yes<br/>                 Swelling of feet, ankles or hands . . . . . No Yes</p> <p>● <b>Respiratory</b><br/>                 Chronic or frequent coughs . . . . . No Yes<br/>                 Spitting up blood . . . . . No Yes<br/>                 Shortness of breath . . . . . No Yes<br/>                 Wheezing . . . . . No Yes</p> | <p>● <b>Gastrointestinal</b><br/>                 Loss of appetite . . . . . No Yes<br/>                 Change in bowel movements . . . . . No Yes<br/>                 Nausea or vomiting . . . . . No Yes<br/>                 Frequent diarrhea . . . . . No Yes<br/>                 Painful bowel movements or constipation . . . . . No Yes<br/>                 Rectal bleeding or blood in stool . . . . . No Yes<br/>                 Abdominal pain . . . . . No Yes</p> <p>● <b>Genitourinary</b><br/>                 Frequent urination . . . . . No Yes<br/>                 Burning or painful urination . . . . . No Yes<br/>                 Blood in urine . . . . . No Yes<br/>                 Change in force or strain when urinating . . . . . No Yes<br/>                 Incontinence or dribbling . . . . . No Yes<br/>                 Kidney stones . . . . . No Yes<br/>                 Sexual difficulty . . . . . No Yes<br/>                 Male - testicle pain . . . . . No Yes<br/>                 Female - pain with periods . . . . . No Yes<br/>                 Female - irregular periods . . . . . No Yes<br/>                 Female - vaginal discharge . . . . . No Yes<br/>                 Female - # of pregnancies . . . . . _____<br/>                 Female - # of miscarriages . . . . . _____<br/>                 Female - date of last pap smear . . . . . _____</p> <p>● <b>Musculoskeletal</b><br/>                 Joint pain . . . . . No Yes<br/>                 Joint stiffness or swelling . . . . . No Yes<br/>                 Weakness of muscles or joints . . . . . No Yes<br/>                 Muscle pain or cramps . . . . . No Yes<br/>                 Back pain . . . . . No Yes<br/>                 Cold extremities . . . . . No Yes<br/>                 Difficulty in walking . . . . . No Yes</p> | <p>● <b>Integumentary (skin, breast)</b><br/>                 Rash or itching . . . . . No Yes<br/>                 Change in skin color . . . . . No Yes<br/>                 Change in hair or nails . . . . . No Yes<br/>                 Varicose veins . . . . . No Yes<br/>                 Breast pain . . . . . No Yes<br/>                 Breast lump . . . . . No Yes<br/>                 Breast discharge . . . . . No Yes</p> <p>● <b>Neurological</b><br/>                 Frequent or recurring headaches . . . . . No Yes<br/>                 Light headed or dizzy . . . . . No Yes<br/>                 Convulsions or seizures . . . . . No Yes<br/>                 Numbness or tingling sensations . . . . . No Yes<br/>                 Tremors . . . . . No Yes<br/>                 Paralysis or weakness . . . . . No Yes<br/>                 Head injury . . . . . No Yes</p> <p>● <b>Psychiatric</b><br/>                 Memory loss or confusion . . . . . No Yes<br/>                 Nervousness . . . . . No Yes<br/>                 Depression . . . . . No Yes<br/>                 Insomnia . . . . . No Yes</p> <p>● <b>Endocrine</b><br/>                 Glandular or hormone problem . . . . . No Yes<br/>                 Excessive thirst or urination . . . . . No Yes<br/>                 Heat or cold intolerance . . . . . No Yes<br/>                 Skin becoming drier . . . . . No Yes<br/>                 Change in hat or glove size . . . . . No Yes</p> <p>● <b>Hematologic/Lymphatic</b><br/>                 Slow to heal after cuts . . . . . No Yes<br/>                 Bleeding or bruising tendency . . . . . No Yes<br/>                 Anemia . . . . . No Yes<br/>                 Phlebitis . . . . . No Yes<br/>                 Past transfusion . . . . . No Yes<br/>                 Enlarged glands . . . . . No Yes</p> |
|---|---|---|

**Allergies**

Do you have a history of skin reaction or other adverse reaction to:

- |                                      |   |   |                                      |
|--------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Environmental Substances | <input type="checkbox"/> Pain Medication    | <input type="checkbox"/> Sulfa       |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Foods                    | <input type="checkbox"/> Penicillin         | <input type="checkbox"/> Tape        |
| <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Iodine                   | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Tetanus     |
| <input type="checkbox"/> Codeine     | <input type="checkbox"/> IV Dye                   | <input type="checkbox"/> Silver             | <input type="checkbox"/> Other _____ |

Specify above and any others: \_\_\_\_\_

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors' office of any changes in my medical status. I, hereby, give my permission to the Doctors of AFFILIATED PODIATRISTS to diagnose and administer treatment of my foot condition.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by: \_\_\_\_\_

# AFFILIATED PODIATRISTS, LTD.



## PATIENT AGREEMENTS AND AUTHORIZATIONS

**CONSENT FOR TREATMENT.** I hereby consent to the treatment provided by Affiliated Podiatrists, Ltd. and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. \_\_\_\_\_  
(initial)

**CONSENT FOR PHOTOGRAPHS.** I grant permission for photographs to be taken to assist in documenting my condition. \_\_\_\_\_  
(initial)

**AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.**

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. \_\_\_\_\_  
(initial)

**ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE.**

I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

\_\_\_\_\_  
(initial)

**PRIVACY POLICY.** I acknowledge having received the Practice's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. \_\_\_\_\_  
(initial)

\_\_\_\_\_  
Patient or Authorized Person Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date