AGE _____

**PATIENT NAME** _____ **BIRTHDATE**_____
**HOME ADDRESS** _____
**CITY** _____ **STATE** _____ **ZIP**_____ **SEX M ~ F**

***How did you hear about us?***_____ **MARITAL STATUS** *Single ~ Married ~ Other*

**CONTACT NUMBERS**
Home:_____Cell:_____Work:_____
Email:_____ Please rewrite your Email:_____

SOCIAL SECURITY # _____
PATIENT'S EMPLOYER/SCHOOL _____OCCUPATION_____
PATIENT'S EMPLOYER ADDRESS_____ PHONE_____

SPOUSE NAME_____SOCIAL SECURITY #_____BIRTHDATE_____
SPOUSE EMPLOYER_____ADDRESS_____PHONE_____

**If patient is a minor/who is responsible party:**
Name:_____ Relationship_____Birthdate_____Social Security #_____
Address:_____Phone:_____Sex: M ~ F Employer: _____
Employer Address_____Employer Phone#_____

**IN CASE OF EMERGENCY CONTACT**
Name_____Relationship:_____Phone:_____

***The Federal Government is now asking us to collect this information. Please circle your response:***
**Race:** White ~ Hispanic ~ Latino ~ Black/African American ~ Asian ~ Native Hawaiian ~ American Indian ~ Alaskan Native ~ Pacific Islander Other:_____
**Ethnicity:** Not Hispanic or Latino ~ Hispanic or Latino ~ Prefer not to respond
**Language:** English ~ Spanish ~ Other:_____

**INSURANCE INFORMATION**

**PRIMARY INSURANCE** SUBSCRIBER/ID GROUP
*COMPANY NAME*_____NUMBER_____NUMBER_____

**SECONDARY INSURANCE** SUBSCRIBER/ID GROUP
*COMPANY NAME*_____NUMBER_____NUMBER_____

**ATTENTION: IF YOUR INSURANCE SUSCRIBER IS SOMEONE OTHER THAN YOURSELF PLEASE PROVIDE THE FOLLOWING:**

Subscriber Name_____ Birthdate_____
Address_____City_____State_____Zip_____
Phone _____ Social Security #_____Relationship_____
Employer Name & Address_____Phone_____

It is the policy of our office that **all fees are due at the time services** are rendered either by cash, check or credit *card unless prior arrangements have been made.* We are happy to discuss fees prior to treatment in order to avoid misunderstandings. We are happy to file your claim to your primary and secondary insurance companies. Regardless of insurance coverage, **you are personally responsible for payment of your account.** If you are unable to pay your balance in full after insurance has processed, we require monthly payments to avoid interest charges. I acknowledge the above statement:

Signature X _____ Date: _____

1. What is your foot problem? _____

_____

2. When did it start? _____

3. Have you had foot treatment before? Y or N By whom? _____

4. Have you had any serious illness or been hospitalized in the past year? Y or N

If so, please explain _____

5. Please list any significant medical problems such as high blood pressure and Diabetes

_____

_____

| List any medications you are taking: | List any allergies: | List any surgeries: |
|---|---|---|
| 1. _____ | 1. _____ | 1. _____ |
| 2. _____ | 2. _____ | 2. _____ |
| 3. _____ | 3. _____ | 3. _____ |
| 4. _____ | 4. _____ | 4. _____ |

***FOR DOCTORS USE ONLY***

9. Complaint _____

Subjective - Objective Symptoms - Signs

_____

_____

PODIATRIC PHYSICAL

Skin/Lesions Location _____

Nails WNL _____ Mycotic _____ Incurvated _____

VASCULAR/NEURO

DP R _____ PT R _____ Sensorium _____ Achilles _____ Babinski _____

DP L _____ PT L _____ Neuropathy _____ Patellar _____ Clonus _____

INTRINSIC/EXTRINSIC-MUSCLE ABNORMALITIES

Leg _____ Foot _____

_____ _____

MUSCULO-SKELETAL DEFORMITIES

Forefoot

HAV R____ L____

HD 2R 2L 3R 3L 4R 4L 5R 5L

Neuroma 2-3R____ 2-3L____

PF met 2R 2L 3R 3L 4R 4L 5R 5L

Tailor's bunion 5R____ 5L____

Heel spur R____ L____

Haglund's deformity R____ L____

BIOMECHANICAL EXAM

A. Pes Cavus/Planus

B. Rigid/Semi-Rigid/Flexible

C. Forefoot Varus/Valgus

D. R.O.M.: M.P.J. R____ L____

M.T.J. R____ L____

S.T.J. R____ L____

Ankle R____ L____

TENTATIVE DIAGNOSIS

_____

_____

_____

NAME _____

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

ITEM 070-5962/25950 © MAY 2002