



Northeast Foot & Ankle Specialists

NAME _____
 LAST FIRST MIDDLE
 ADDRESS _____
 STREET APT# CITY STATE ZIP
 HOME PHONE () WORK PHONE () CELL PHONE ()
 AGE DATE OF BIRTH SOCIAL SECURITY NO SEX M F
 YOUR OCCUPATION EMPLOYER
 EMPLOYER'S ADDRESS EMPLOYER PHONE
 MARITAL STATUS (CIRCLE) S M W D EMAIL
 EMERGENCY CONTACT RELATIONSHIP
 HOME PHONE WORK PHONE EXT.

PRIMARY INSURANCE POLICY ID NO. GROUP NO.
 SUBSCRIBER DOB SOCIAL SECURITY NO.
 HMO PPO
 SECONDARY INSURANCE POLICY ID NO. GROUP NO.
 SUBSCRIBER DOB SOCIAL SECURITY NO.
 HMO PPO
 GUARANTOR ()
 ADDRESS
 RELATIONSHIP TO PATIENT

PRIMARY CARE PHYSICIAN PHONE ()
 PHYSICIAN'S HOSPITAL AFFILIATION DATE OF LAST VISIT
 WHO REFERRED YOU TO OUR OFFICE

WHAT IS YOUR FOOT PROBLEM
 HOW LONG HAVE YOU HAD THIS PROBLEM HAVE YOU BEEN TREATED FOR IT? YES NO
 BY WHOM?

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

PATIENT/GUARDIAN SIGNATURE

DATE

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Northeast Foot & Ankle Specialists and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. _____

(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 Northeast Foot & Ankle Specialists, PC. I authorize Northeast Foot & Ankle Specialists, PC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Northeast Foot and Ankle Specialists, PC 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 Northeast Foot & Specialists, PC for insurance benefits payable to me. I understand that I am financially responsible to Northeast Foot & Ankle Specialist, PC for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. _____

(initial)

PRIVACY POLICY. I acknowledge having received the Northeast Foot & Ankle Specialist's PC, "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, are 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 that NE Foot & Ankle Specialist's , PC has already made disclosures with my prior consent. _____

(initial)

HMO POLICIES, I understand that it is my responsibility to obtain referrals from my primary care physician. If I do not supply NE Foot & Ankle Specialists, PC with a referral for any appointment where one is required, I understand that I will be responsible for payment in full at the time of service. _____

(initial)

RETURNED CHECKS, I understand that I will be charged \$30 for any returned check from the bank for "non-sufficient funds". _____

(initial)

MEDICAL RECORDS REQUESTS, I understand there will be, at minimum, a \$25 fee for requests for medical records from any party other than my health insurance company and that this fee will be paid prior to the records being released. An additional fee of \$10 will be charged for copies of xrays in either disc or photo format. You will not be charged for any literature handed out to you by the office or one of the doctors unless told so upfront. If just a small amount of documentation is requested this can be given to you the patient at the doctor's discretion without requiring payment.

_____(initial)

Systems Review

Psychology

Depression Yes No
High stress level Yes No
Sleep disturbances Yes No
Suicidal ideation Yes No
Eating disorder Yes No
Panic attacks Yes No

Musculoskeletal

Joint stiffness Yes No
Joint pain Yes No
Joint swelling Yes No
Joint redness Yes No

Constitutional

Weight gain Yes No
Loss of appetite Yes No
Fever Yes No
Weakness Yes No
Night sweats Yes No
Weight loss Yes No
Fatigue Yes No

ENT

Cold Yes No
Nose bleed Yes No
Hearing loss Yes No
Sore throat Yes No
Ringing in ears Yes No
Dry mouth Yes No

Cardiology

Dizziness Yes No
Palpitations Yes No
Chest pain Yes No
Leg swelling Yes No
Hypertension Yes No

Gastroenterology

Blood in stool Yes No
Diarrhea Yes No
Vomiting Yes No
Constipation Yes No
Nausea Yes No
Difficulty swallowing Yes No
Abdominal pain Yes No
Change in bowel habits Yes No
Heartburn Yes No

Hematology/Lymph

Swollen glands Yes No

Dermatology

Rash Yes No
Hives Yes No
Raynaud's Yes No

Endocrinology

Excessive sweating Yes No
Excessive thirst Yes No
Excessive urination Yes No
Cold intolerance Yes No
Heat intolerance Yes No
Diabetes Yes No

Neurology

Tingling numbness Yes No
Seizures Yes No
Memory loss Yes No
Weakness Yes No
Restless leg symptoms Yes No
Tremor Yes No
Gait difficulties Yes No
Peripheral neuropathy Yes No

Ophthalmology

Vision loss Yes No
Blurring of vision Yes No

Respiratory

Shortness of breath Yes No
Cough Yes No

Allergy

Runny nose Yes No
Scratchy throat Yes No
Sinus congestion Yes No

Urology

Dysuria Yes No
Hematuria Yes No
Frequent urination Yes No
Urinary incontinence Yes No
Recurrent UTI Yes No
Nocturia 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"/> Psychological Problems |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Ear/Nose Throat Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Prolonged Bleeding | _____ |

HEIGHT _____ WEIGHT _____

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 If yes, what substance(s)? _____

MEDICAL INFORMATION

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 _____

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: _____

PHARMACY USED: _____ LOCATION: _____

PHONE: _____ FAX: _____

NOTES: _____

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 Drs. Bregman and Berman to diagnose and administer treatment of my foot condition.

Signature _____ Date _____ Reviewed by: _____