PALISADES PODIATRY ASSOCIATES, LLP

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REGISTRATION FORM

(Please print clearly)

Today's Date _____/_____/_____ PLEASE FILL IN DATE

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss
Street Address	City	State	Zip Code

Home Phone #	Work Phone #	Cell Phone #	Email Address:
( ) -	( ) -	( ) -	

Date of Birth	Age	Social Security #	Marital Status	Gender
/ /		/ /	☐Single ☐Married ☐Widow ☐Divorced	☐ M ☐ F

INSURANCE INFORMATION

Occupation	Insured's Employer

Insured's Employer's Address

Please indicate primary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Co-Payment Amount $

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured's Birth Date** / /

Please indicate secondary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Co-Payment Amount $

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

Does your plan require a referral?
☐ Yes ☐ No

If Yes, was a referral obtained?
☐ Yes ☐ No

Referral #:

FAMILY PHYSICIAN INFORMATION

Medical Doctor's Name	Medical Doctor's Phone Number ( ) -

Medical Doctor's Street Address	City	State	Zip Code

Date of last physical exam _____/_____/_____	Date of last blood test _____/_____/_____

WHO REFERRED YOU TO OUR PRACTICE?

☐ Doctor ______________________

☐ Hospital ______________________

☐ Insurance Plan ______________________

☐ Family ______________________

☐ Friend ______________________

☐ Website ______________________

☐ Other ______________________

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MEDICAL HISTORY

PATIENT NAME	BIRTH DATE	/ /

ALLERGIES *(LIST KNOWN ALLERGIES TO DRUGS/MEDICATIONS – AND SPECIFIC REATIONS TO THEM*

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Iodine on Skin	☐ Aspirin
☐ Codeine	☐ Tape	☐ Anti-inflammatory Medication	☐ Other:	

If any allergies, what type of reaction? ☐ Difficulty breathing ☐ Rash ☐ Stomach upset

MEDICATIONS *CURRENT MEDICATIONS YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	MEDICATION	MEDICATION	MEDICATION

FOOT AND ANKLE HISTORY

What foot/ankle problem brings you to the doctor?	**How Long?**		Shoe Size:

How have you been treated for the current problem?

☐ Surgery	☐ Orthotics	☐ Oral Medications	☐ Cortisone Shots

Do you have an X-Ray, MRI, or CT Scan for the current problem? ☐ Yes ☐ No

Blood Pressure	**Height**	**Weight**

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetic Foot Ulcers	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Stomach Ulcers / Reflux / Heartburn	☐ Yes	☐ No
Heart Disease or Attack	☐ Yes	☐ No	Other:		
Heart Murmur	☐ Yes	☐ No	Other:		
Hepatitis (Indicate) ☐ A☐ B☐ C	☐ Yes	☐ No	Other:		

Do you drink?	☐ Yes ☐ No If Yes, Drinks per week
Do you smoke?	☐ Yes ☐ No If Yes, Pack(s)/day
Are you pregnant?	☐ Yes ☐ No
Which PHARMACY do you use?	

PATIENT NAME			BIRTH DATE	/ /	
Orthopedic/Podiatric	☐ Yes	☐ No	Circulation (Bypass, Angioplasty)	☐ Yes	☐ No
Heart	☐ Yes	☐ No	Aneurysm	☐ Yes	☐ No
Tumor	☐ Yes	☐ No	Head and Neck	☐ Yes	☐ No
Abdominal	☐ Yes	☐ No	Other:		
Have you ever been put to sleep for surgery? ☐ Yes ☐ No			Any problems with anesthesia? ☐ Yes ☐ No		

Relative	***Alive***	***Deceased***	***Age Deceased***	***Cause of Death (Heart Problems, Cancer, Diabetes, Etc.)***
Father	☐	☐		
Mother	☐	☐		
Siblings	☐	☐		
	☐	☐		

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X	/ /
Patient/Guardian Signature	Date
History Reviewed By: Dr. Signature	**Date**

ASSIGNMENT AGREEMENT

Our office has agreed to bill your insurance company for payment of your office visit/s. The patient is responsible for all co-payment and deductibles specified by the insurance company. I request that payment of authorized insurance benefits be made to:

Palisades Podiatry Associates, LLP

____
Signature of Patient or Legal Guardian

______________________________ ____________________
Patient's Name Date

EMERGENCY CONTACT INFORMATION

NAME : ______________________________

RELATIONSHIP: ________________________ **WORK NUMBER: (____)**______________

HOME PHONE: ________________________ **CELL NUMBER: (_____)**____________

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Pomona, New York 10970
(845)362-0100

PATIENT HIPAA AWARENESS

With my permission, Dr. Barry Schoenberg and Dr. Jeffrey Horowitz of Palisades Podiatry Associates, LLP, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Palisades Podiatry Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Palisades Podiatry Associates, LLP reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, Palisades Podiatry Associates, LLP may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, Palisades Podiatry Associates, LLP may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, Palisades Podiatry Associates, LLP may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Palisades Podiatry Associates, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Palisades Podiatry Associates, LLP to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____
Signature of Patient or Legal Guardian

____________________________________ _____________________
Patient’s Name Date

____
Print Name of Patient or Legal Guardian