

**PARK AVENUE PODIATRY ASSOCIATES, P.C.**  
**PATIENT INFORMATION SHEET**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible party (if patient is a minor): \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Home phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip-code: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone #: \_\_\_\_\_

Employer address: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Primary Care MD: \_\_\_\_\_

Physician's address: \_\_\_\_\_ Physician's phone #: \_\_\_\_\_

Emergency contact information: \_\_\_\_\_

Name of insured: _____	Relation to patient: ____	Date of Birth: _____
Primary Insurance: _____	Phone #: _____	
Primary Insurance address: _____		
Policy #: _____	Group #: _____	Copay Amount: _____
Do you need a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Secondary Insurance: _____	Policy #: _____	
Secondary Insurance address: _____		

**RELEASE AND ASSIGNMENT**

I, the undersigned, hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by my physician/provider on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician/provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, the undersigned, have coverage with the insurance company listed above and assign directly to Park Avenue Podiatry all claim benefits, if any, otherwise payable by me for services rendered. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician whether or not paid by the insurance. If any portion of my account balance is not reimbursed by my insurance company for any reason, I agree to cooperate and arrange prompt payment in full to clear my bill. I understand that payment is due upon receipt of my monthly statement.

This Release and Assignment is effective for the period of 2009-2013.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

THIS AUTHORIZATION DOES NOT APPLY TO MEDICARE PATIENTS WHO ARE FEE PAYING (AS A COURTESY WE WILL FILE MEDICARE INSURANCE CLAIMS). IF YOU HAVE MEDICARE, PLEASE SIGN BELOW, ACKNOWLEDGING THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF YOUR KNOWLEDGE.

Signature of Medicare Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# PARK AVENUE PODIATRY ASSOCIATES

## PODIATRIC HISTORY AND PHYSICAL EXAMINATION

Name \_\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Male

Female

### **To be completed by the patient:**

#### **REASON FOR VISIT** (Describe foot problems and concerns)

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#### **MEDICAL HISTORY** (Check if you had or have any of the following)

- Diabetes     Type I     Type II     Controlled     Uncontrolled
- Hypertension (High Blood Pressure)     Tuberculosis     Asthma     Kidney Disease
- Bleeding/Clotting Disorders     Rheumatic Fever     Anemia     Gout
- PVD (Circulation Disease)     Arthritis     Cancer     Epilepsy
- Hepatitis (Liver Disease)     Stomach Ulcers     Cramps or numbness in feet or legs
- Heart Disease     Other(s) \_\_\_\_\_

#### **MEDICATIONS** (Including Non-Prescription/Over-The-Counter Medications)

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#### **ALLERGIES**

- No Known Drug Allergy
- Penicillin     Aspirin     Codeine     Latex     Egg     Sulfa     Iodine
- IV Dye     Local Anesthetic     Adhesive Tape     Other(s) \_\_\_\_\_

#### **PAST SURGICAL HISTORY** (Please include date of surgery)

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#### **SOCIAL HISTORY**

- Smoking (packs/day # or years) \_\_\_\_\_     Alcohol \_\_\_\_\_     Recreational Drugs
- Sexually Transmitted Disease \_\_\_\_\_     Other \_\_\_\_\_

#### **FAMILY HISTORY**

- Diabetes     Heart Disease     Cancer     Hypertension     Anemia     Stroke

I hereby give permission to Park Avenue Podiatry Associates to examine and/or administer treatment as necessary in the diagnosis and/or treatment of my foot problem(s). I also hereby give my consent for East Side Podiatric Medical Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I hereby authorize payment directly to the physician providing services for which benefits are payable.

**SIGNED** \_\_\_\_\_

**DATE** \_\_\_\_\_

If signed as parent/guardian, state relationship to patient \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT

OF

# NOTICE OF PRIVACY PRACTICES

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature

## Addendum

I hereby authorize the following family member, relative or designated representative access to protected health and/or billing information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_ Protected Health Information

\_\_\_ Billing Information