Essex Podiatry Associates

Jeffrey N. Kaplan, DPM   Neil E. Goldberg, DPM

General Vital Information

Date: ____

Name: ______________________________________ Nickname: ____________________

Sex: M / F SS #:______________________________ DOB: ________________________

E-mail: ______________________________________ Home #: _____________________

Address: ____________________________________ Work #: ______________________

City: ______________ State: ______Zip:_________ Cell #: _______________________

Primary Care Physician: ________________________ PCP Phone: __________________

PCP Address: _________________________________ Last Visit: ____________________

Emergency Contact Name:______________________ EC Phone: ___________________

Relationship to Patient: _________________________

Marital Status: Single   Married   Partner   Spouse/Partner name: _____________________

Widowed   Divorced

Employer/School: ____

Employer's Address: ____

Please provide a copy of your insurance card to our staff.

Primary Ins.Name: ______________________ Policy# ______________Group# ____________

Subscriber Name: _______________________ DOB: _____________ Relationship: __________

Mailing Address: ____

Secondary Ins.Name: _____________________ Policy# ______________Group# ___________

Subscriber Name: _______________________ DOB: _____________ Relationship: __________

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor’s assistants) to administer and perform such procedures upon me as the doctor deems necessary.

____ _________________________

Signature of Patient, Parent, Guardian or Personal Rep.   Print name

___________________________________ ________________________

Relationship to Patient   Date

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MEDICAL INFORMATION

NAME: ____

PODIATRIC HISTORY

What is the main complaint for which you came to be treated? ________________________
____
____

How long has this bothered you? _____ Days ______ Weeks ______Months _____ Longer

What treatments have you tried?
____
____
____

Have you ever been to a podiatrist before: Yes No Last visit: ____________________
How did you hear about our office? ______________________________________
Please indicate which foot problems you now have or have had in the past:

__ Ankle Pain
__ Ankle instability (easy twisting injuries)
__ Ankle swelling or stiffness
__ Corns/ Calluses
__ Achilles Tendon Pain
__ Plantar Warts
__ Leg Pain
__ Fungal Toenails
__ Bunions
__ Athlete's Foot
__ Ingrown Toenails
__ Numbness in feet/toes or legs
__ Flat Feet
__ Cramps in feet or legs
__ "Toe-in" or "Toe-out" gait (walking)
__ Heel or Arch Pain
__ Swelling in feet or ankles
__ Pale or blue discoloration of the feet
__ Non/poor healing sore, ulcer or gangrene on the leg or foot
__ Pain or fatigue of feet or legs during activity or exercise

SHOES:

Shoe Size __________________ Height _________________ Weight ________________

What type of shoes do you wear most often? ______________________________________

SOCIAL HISTORY

Do you smoke? Yes No
Did you smoke in the past? Yes No
Do you drink alcohol? Yes No

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Name: ____

Please answer the following questions completely.

MEDICAL HISTORY

Please indicate if you have a problem with any of the following:

Condition			Condition		
AIDS/HIV	Yes	No	Hepatitis or Jaundice	Yes	No
Alcoholism	Yes	No	High / Low Blood Pressure	Yes	No
Allergies	Yes	No	High Cholesterol	Yes	No
Anemia	Yes	No	Kidney Problems	Yes	No
Angina	Yes	No	Liver	Yes	No
Arthritis	Yes	No	Musculoskeletal	Yes	No
Artificial Heart Valves/Joints	Yes	No	Neurological	Yes	No
Asthma	Yes	No	Neuropathy	Yes	No
Back Problems	Yes	No	Phlebitis	Yes	No
Blood Disorders	Yes	No	Blood Clot/DVT/PE	Yes	No
Breathing Problems	Yes	No	Radiation Treatment	Yes	No
Cancer	Yes	No	Rash	Yes	No
Chemical Dependency	Yes	No	Respiratory Disease	Yes	No
Circulation problems	Yes	No	Rheumatic Fever	Yes	No
Depression/anxiety	Yes	No	Shortness of Breath	Yes	No
Diabetes (type 1, type 2)	Yes	No	Sinus Problems	Yes	No
Ear Problems	Yes	No	Skin Disorder	Yes	No
Depression/anxiety	Yes	No	Sleep Apnea	Yes	No
Diabetes (type 1, type 2)	Yes	No	Stomach	Yes	No
Ear Problems	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Thyroid	Yes	No
Eye Problems	Yes	No	Tuberculosis	Yes	No
Gout	Yes	No	Ulcers	Yes	No
Headaches	Yes	No	Varicose Veins	Yes	No
Heart Disease	Yes	No	Venereal Disease	Yes	No
Heart Murmur	Yes	No	Weight Loss, unexplained	Yes	No
Hemophilia	Yes	No			

Other:____

Are you pregnant? **Yes** **No**   **Are you nursing?** **Yes** **No**

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MEDICAL INFORMATION

NAME: ______________________________

MEDICATIONS

Please list current prescriptions prescribed by a doctor, including over the counter medications, vitamins and supplements.

____

____

____

____

Pharmacy Name ______________________________   Pharmacy Phone # ______________________________

Pharmacy Town

ALLERGIES

Are you allergic or sensitive to any of the following:

☐ Penicillin ☐ Sulfa ☐ Tape ☐ Latex ☐ Betadine (iodine) ☐ Aspirin ☐ NONE
☐ Tylenol ☐ Ibuprofen ☐ Vicodin ☐ Codeine ☐ Other (specify) ______________
☐ Local or general anesthesia

SURGICAL HISTORY

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ YES ☐ NO
If yes, please describe surgeries you have had: ______________________________

____

____

Do you have any artificial joints? Where? ☐ YES ☐ NO ______________________________

Do you have an artificial heart valve? ☐ YES ☐ NO

FAMILY HISTORY

Is there any family history of any of the following: (Please circle if applicable)

Arthritis	Bleeding Disorder	Blood Clot/DVT/PE	Bunions
Cancer	Circulation Problems	Diabetes	Neurological
Heart Disease	Strokes	Other (specify):______________	

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Medical Information Release Form
(HIPAA Release Form)

Name: ___________________________________Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

__ Spouse ________________________________

__ Partner ________________________________

__ Children ______________________________

__ Other _________________________________

___ Information is Not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call : home phone: ___________ work phone: _____________ cell phone: __________

Email: ____

If unable to reach me:

_____ Leave me a detailed message.
_____ Please leave a message asking me to return your call.

____ Other ____

The best time to reach me is: (day/evening)___________________ times: _______________

_________________________________ ________/_____/_______
Signature of Patient Date

_________________________________ _______/_____/________
Witness Date

HIPAA AUTHORIZATION FORM

Patient Authorization for Use and Disclosure of Protected Health Information

By signing below, I authorize Dr. Neil Goldberg and/or Dr. Jeffrey Kaplan to use and/or disclose certain protected health information (PHI) about me to the following:

- Health Care Professionals
- Patients' Insurance Company
- Parties authorized by patient

This authorization permits Dr Goldberg and/or Dr. Kaplan to use or disclose the following individually identifiable health information about me: my medical/surgical history, medications, lab values and radiographic imaging. This authorization will not expire. Dr Goldberg and/or Dr. Kaplan will not receive payment or any other remuneration from a third party in exchange for using or disclosing PHI.

I understand that I do have to sign this authorization to receive treatment from Dr. Goldberg and/or Dr. Kaplan. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I have the right to revoke the authorization in writing except to the extent the Dr. Goldberg and/or Dr. Kaplan has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at the Essex Podiatry Associates' office.

Signed By: ______________________________ ______________________

Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________

Printed Patient's Name Date

The patient/guardian will be provided with a signed copy of this authorization form upon request.

FOR MEDICARE PATIENTS, PLEASE READ AND SIGN BELOW

MEDICARE PATIENTS' CERTIFICATION/ AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given to Dr. Goldberg/Dr. Kaplan is applying for payment under title XVII of the Social Security Act is correct and I request payment of the authorized Medicare/Insurance benefits be made to Dr. Neil Goldberg, DPM and/or Dr. Jeffrey Kaplan, DPM on my behalf, for any services furnished to me by or in the office including physician services. I authorize any holder of medical and other information about me, to release to Medicare/Insurance and its agents or intermediaries any information needed to determine these benefits or benefits for related services.
I further authorize the Medicare/Insurance program to furnish medical or other information acquired on the visit acquired by its intermediary under the Title XVII Program to the extent necessary to process any complimentary coverage claim.

I hereby certify that I have read fully understand the above authorization.

Signed By: ______________________________ ______________________

Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________

Printed Patient's Name Date

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UNDERSTANDING YOUR RESPONSIBILITY

If you have a deductible and you have not met it yet, you may be responsible to pay out of pocket until you have met your deductible. Only then will your insurance will start paying for your visits.

If you have a co-pay, it is your responsibility to pay it at the time of your visit.

The cost of orthotics not covered under your insurance plan, is your responsibility.

I ___________________________(print name) have read and understand my responsibility and am willing to pay any balance and fees on my account, which are not part of my insurance coverage.

Signature ___________________________

Date ______________________

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