Name: _____ **Birthdate:**_____ **Chart #** _____

Sex: □ M □ F Age_____ Marital Status: □ Single □ Married □ Widowed □ Divorced

SS# _____ Spouse/Partner Name_____

Address**:** _____

City: _____ State:_____ Zip_____

Home #: _____ Cell#:_____

Primary Care Physician:_____ Phone:_____ Date last seen:_____

Employer: _____ Work #: _____

Address: _____

Primary Insurance: _____ Are you the insured? □ Yes □ No

Insured Information

Subscriber Name: _____ Relationship to insured: □ Spouse □ Child □ Self □ Other

Phone #: _____ Sex: □ M □ F Birthdate _____

Address: _____

Policy ID: _____ Group ID: _____

Secondary Insurance: _____ Are you the insured? □ Yes □ No

Insured Information

Subscriber Name: _____ Relationship to insured: □ Spouse □ Child □ Self □ Other

Phone #: _____ Sex: □ M □ F Birthdate _____

Address: _____

Policy ID: _____ Group ID: _____

How did you find out about our practice? □ Physician □ Internet □ Telephone book □ Family member
□ Friend □ Other _____

What is the reason for your visit today?_____

How long has this bothered you? 1 2 3 4 5 6 7 □ days □ weeks □ months □ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: □ burning □ constant □ dull □ sharp □ shooting □ throbbing □ tingling

other: _____

DATE:

History and Physical

Medical History: Place a mark on "Yes" or "No" to indicate if you have **HAD** any of the following :

Liver Disease	□ Yes □ No	Gout	□ Yes □ No	Diabetes:	□ Yes □ No
Heart Murmur	□ Yes □ No	Depression	□ Yes □ No	(Circle one:)	Type 1 , Type 2
Blood Clot	□ Yes □ No	Thyroid Disease	□ Yes □ No	HIV	□ Yes □ No
Neuropathy	□ Yes □ No	Circulatory Problems	□ Yes □ No	Skin Disorders	□ Yes □ No
Arthritis	□ Yes □ No	Anxiety	□ Yes □ No	Breathing Problems	□ Yes □ No
Alcoholism	□ Yes □ No	High Blood Pressure	□ Yes □ No	Asthma	□ Yes □ No
Sleep Apnea	□ Yes □ No	Heart Disease	□ Yes □ No	Kidney Problems	□ Yes □ No
High Cholesterol	□ Yes □ No	Mental Illness	□ Yes □ No	Hepatitis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Cancer	□ Yes □ No	Stroke	□ Yes □ No

Other (Please Specify):_____

Female patients only: **Are you pregnant?** □ Yes □ No **Are you nursing?** □ Yes □ No

Family History *Is there any immediate family history of: (Please indicate immediate family member)*

□ Alzheimer's	_____	□ Cataracts	_____	□ Heart Disease	_____
□ Arthritis	_____	□ Circulation problems	_____	□ High Blood Pressure	_____
□ Bleeding disorders	_____	□ Depression	_____	□ Neurological	_____
□ Blood Clot	_____	□ Diabetes:(Type 1/Type 2)	_____	□ Strokes	_____
□ Cancer	_____	□ Emphysema	_____	□ Other (*specify*)	_____

Social History

Do you smoke? □ Yes □ No If yes, how many packs per day? □ 1 □ 2 □ 3 □ 4 □ 5 For how long?_____

Do you drink alcohol? □ Yes, everyday (5-7 days/week) □ Yes, occasionally/socially □ No, rarely

Substance abuse: □ Yes, I have a current substance abuse problem. Please specify: _____

□ Yes, I had a past substance abuse problem. Please specify:__ _____

□ No, I have never had a substance abuse problem.

Surgical History □ None

Please list ***any*** surgeries you have had: _____

_____

_____

Do you have any artificial joints? □ Yes (where ? _____) □ No Do you have an artificial heart valve? □ Yes □ No

Review of Systems: *(Please check the box if you **CURRENTLY** have any of these symptoms)*

Cardiovascular	□ chest pain/pressure	□ fainting	□ leg pain when walking	□ palpitations		
	□ cold hands/feet	□ fever	□ leg swelling	□ valve problems	□ vascular disease	
Gastrointestinal	□ abdominal pain	□ constipation	□ diarrhea	□ increased appetite	□ vomiting	
	□ blood in stool	□ decreased appetite	□ heartburn	□ trouble swallowing	□ ulcers	
Hematologic	□ anemia	□ blood thinners	□ clotting disorders	□ lower leg ulcers	□ sickle cell disease	
Integumentary	□ athletes foot	□ dry, scaly skin	□ itchiness	□ keloids	□ nail abnormalities	
Musculoskeletal	□ arthritis	□ joint instability	□ joint stiffness	□ muscle pain	□ neck pain	
	□ back pain	□ joint pain	□ joint swelling	□ muscle weakness	□ sciatica	
Neurological	□ headaches	□ numbness	□ paralysis	□ seizures	□ tingling	□ tremors □ weakness
Respiratory	□ chest pain	□ COPD	□ coughing	□ emphysema	□ snoring	□ wheezing

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. _____

(Patient Signature)

Name: _____ **Date of Birth:**_____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ White □ Hawaiian or Pacific Islander □Decline to Specify

Ethnicity/Nationality: □Hispanic or Latino □ Not Hispanic or Latino □ Decline to Specify

Privacy Information Preferences:

Were you offered a copy of the HIPAA Privacy Practice Notice?..... □ Yes □ No

Do you want to be exempt from any public reporting?..... □ Yes □ No

ie: In the event of an epidemic, the government would pull your information for research

Can we send a bill to your address on file? ..... □ Yes □ No

Can we call the phone number listed to speak to you/confirm appointments? ..... □ Yes □ No

Can we leave a message on answering machine? ..... □ Yes □ No

Do you allow internet based delivery of reminders?..... □ Yes □ No

Other than yourself, who can we leave a message with?.....

□ Wife □ Husband □ Mother □ Father □ Daughter □ Son □ Other_____

Smoking Status:

□ Current every day smoker
□ Current some day smoker
□ Former smoker
□ Never smoker
□ I decline to answer

Flu Vaccination:

□ Yes, I have received my Vaccination
□ No, I have not received my Flu Shot

Pneumococcal Vaccine:

□ Yes, I have received my Vaccination
□ No, I have not received my Shot

Vital Signs:

Blood Pressure: _____
Weight: _____
Height: _____

Have you fallen in the last 12 months? □Yes □No

If yes; were you injured from the fall? □ Yes □No

Orthopedic Exam:

Right Shoe Size: _____ Narrow Medium Wide

Left Shoe Size: _____

Have you completed any Advanced Directives: □Yes □No

If yes; check any that apply: □ Power of Attorney □ Living Will □ Do Not Resuscitate Order

Current Medications: □ None

Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____
Name: _____ Dose:_____

Use the back of this form if more room is needed

Allergies: **Reaction**

□ No known allergies
□ Penicillin _____
□ Seafood _____
□ Sulfa _____
□ Tape _____
□ Latex _____
□ Betadine (Iodine) _____
□ Aspirin _____
□ Tylenol _____
□ Ibuprofen _____
□ Codeine _____
□ Other (specify) _____

Pharmacy Name: _____ **Pharmacy Phone:**_____

Pharmacy Address:_____

PLEASE READ AND SIGN: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible to inform the physician and/or medical staff of any and all updates to the information listed above, and I give my permission for the office staff to obtain my prescription information via SureScripts.

Patient Signature: _____ **DATE:** _____

Capital Foot Specialists
713 Troy Schenectady Rd, Ste 222
Latham, NY 12110
(518) 785-1110

Capital Foot Specialists
1217 Curry Road
Schenectady, NY 12306
(518) 355-0043

PATIENT RELEASE AUTHORIZATION

Date:

I, _____, hereby authorize that Robert J. Califano, DPM, Mary B. Lodge, DPM, Kurt Relation, DPM, and staff are allowed to release all copies of my records and discuss all information pertaining to my treatment for all dates of care including diagnosis, treatment, prognosis, x-rays, pathology reports, and all other pertinent information with regards to myself to:

_____.

_____ _____
Patient or Responsible Party Witness

EMERGENCY CONTACT

In the event of an emergency, please list the name and telephone number of the individual you would like us to contact :

Emergency Contact : _____

Relationship: _____

Phone #: _____

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Latham, NY 12110
(518) 785-1110

Capital Foot Specialists
1217 Curry Road
Schenectady, NY 12306
(518) 355-0043

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 Privacy Pract*ices.

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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do then you are bound to abide by such restrictions.

Patient/Guardian Name: _____

Signature: _____

Date: _____

FOR 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:

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash, or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan that we do not participate with, all charges for your care and treatment are due at the time of service. We will then prepare you a detailed receipt that you have the option to forward to your insurance carrier.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.
- There is a service fee of $20.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party:_____ Date:_____