WELCOME TO DR. KLEIN'S OFFICE

Last Name: First Name: Date of Birth:

Address: Zip Code:

Home Phone: Cell Phone: Business Phone:

SS #: Primary Physician: Gender: M F

Employer & Address: Occupation:

Health Insurance Name & ID #:

Name of Insured: Insured's Date of Birth:

Insured's Address: Insured's SS #:

Secondary Ins Name of Insured Insured's Date of Birth:

Emergency Contact & Phone: Relationship:

How did you hear about Dr. Klein?

Have you had previous treatment by a Podiatrist?

My chief foot complaint is:

How long? Which foot?

If painful, circle what makes the pain worse: Walking Sitting Standing Shoes First Step Out of Bed

Personal Medical History: Please circle all that apply to you

Diabetes	Neuropathy	Heart Condition	Heart Attack
Anemia	Raynaud Disease	Poor Circulation	High Blood Pressure
Phlebitis	Stroke	Hearing/Ear	Vision/Eye Problems
Thyroid	Gout	Kidney Disease	Dark Urine
Sciatica	Arthritis	Osteoporosis	Lyme's Disease
Alzheimer's	Seizure Disorder	Headaches	Psychiatric Disorder
Asthma	Tuberculosis	Lung Disorder	Nerve Disorder
Liver Disease	Hepatitis	HIV Positive	Cancer
GERD	Stomach Ulcer	Pregnancy: Yes	No
Bleeding Disorders		Slow to Heal: Yes	No
Joint Implants		Vascular Grafts	
Other:			

Personal Surgical History: Please provide a list of all prior surgeries

Family Medical History: Please circle all that apply to family members

Diabetes	Heart Condition	Stroke	High Blood Pressure
Gout	Arthritis	Cancer	Foot Problems

Medication History:

Do you take Coumadin: Yes No Do you take Insulin: Yes No

Please provide a list of all other medications and the reason why you take them:

Allergies: Please circle all that apply

Penicillin	Sulfa	Codeine	Other Antibiotics
Aspirin	Aleve/Motrin	Tylenol	Pain Medications
Novocain	Shrimp/Iodine	Latex	Adhesive Tape

Signature:

Print Name: Today's Date: / /

Dr. Stanley Klein, DPM

Patient Privacy Notice
Acknowledgment Form

The purpose of this form is to record acknowledgment of receipt of Privacy Notice, as required by the Health Information Portability and Accountability act of 1996 (HIPPA). Should such acknowledgment be unobtainable, this form will document the company's good faith attempt to acquire such acknowledgment.

Part A: I_____ acknowledgment receipt of the Dr. Stanley Klein's Privacy Notice and Practices.

X Signed: _____ Date: _____

OVER

Part B: Dr. Klein made a good faith attempt to obtain _____ acknowledgment of receipt of Privacy Notice, but was unable to do so for the following reason(s):

Individual refused to sign

Communications barriers prohibited obtaining it

An emergency situation prevented us from obtaining it

other (please specify) _____

_____

Employee Sign: _____ Position: _____ Date: _____

Part C: The first treatment encounter of the office with _____ was by telephone on _____ and a copy of the Notice of Privacy Practices of the office and a copy of this Acknowledgment From were mailed to the patient on such date, with a request to the patient to return to the office to complete **Part A** of this form.

Employee Sign: _____ Position: _____ Date: _____

The completed form is to be placed in the patient's medical record.

(See OVER)

Dr. Stanley Klein, DPM
Board Certified in Foot & Ankle Surgery
Diabetic & Family Car
310 Richmond Hill Road Staten Island, NY 10314 Tel (718)761-0024 Fax(718)761-4923

Patient Authorization Form

I, _____ acknowledge, understand
(Insert patients name)
and authorize the following:

1. Dr Klein and staff are hereby authorized to disclose my protected health information to **any family member** or the person or persons listed below:

_____

_____

2. Dr. Klein and staff have the permission to leave messages pertaining to my private health information on the answering machine or voice mail at my residence. If necessary, I can be called at my place of business.

X **Signature:** _____ **Date:** _____

If signatory is patient's personal representative, state authority to act for patient: _____

Office Of Stanley Klein, DPM
310 Richmond Hill Road Staten Island, NY 10314 (718)761-0024 (718)761-4923 WWW.KLEINPODIATRY.COM

PHARMACY INFORMATION

LAST NAME:_____FIRST NAME:_____

MAILING ADDRESS:_____

CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____

DATE OF BIRTH:_____ _____MALE ____FEMALE

DO YOU HAVE PRESCRIPTION INSURANCE? _____YES _____NO

DRUG ALLERGIES: (CHECK ALL THAT APPLY)

_____NONE _____ASPIRIN _____CODEINE _____IBUPROFEN(ADVIL,MOTRIN,NUPRIN)

_____TETRACYCLINE _____NAPROXEN(ALEVE,ANAPROX) _____SULFA _____PENICILLIN

_____OTHER ANTIBIOTICS (PLEASE LIST) _____

IF YOU HAD AN ALLERGIC REACTION, WHAT TYPE?
(EG; RASH, GI UPSET,DIARRHEA,HIVES,ANAPHLAXIS)

_____

SIGNATURE:_____

DATE:_____

It is always important to notify Dr Klein of any changes in your medical history,

*PHARMACY NAME:_____

PHARMACY ADDRESS:_____

*PHARMACY TELEPHONE NUMBER:_____