PATIENT INFORMATION

NAME________________________________ DATE__________________

(LAST) (FIRST)

ADDRESS____

(STREET) (CITY) (STATE & ZIP CODE)

TEL. (CELL)______________ (HOME)________________ (WORK)______________

DATE OF BIRTH__________________ OCCUPATION__________________________

EMAIL ________________________ GENDER O Male O Female

FAMILY PHYSICIAN________________ ADDRESS______________ LAST VISIT________

Who may we thank for referring you to the office?________________________________

CHIEF FOOT/ ANKLE COMPLAINT____

How long has it been present?__________ OTHER FOOT/ANKLE PROBLEMS______________

Have you been seen by a podiatrist for this or any problem?(Y/N) Last Visit________________

For which problem were you being treated?___________________________________

LIST ANY MEDICATIONS YOU ARE TAKING_______________________________

___________________________PHARMACY__________ PHARM #__________

LIST ANY ALLERGIES TO MEDICATIONS OR FOOD___________________________

Did you receive a Flu shot? (Y) (N) Date____________ Pneumonia vaccination? (Y) (N)

PERSONAL MEDICAL HISTORY
(Circle those for which you have been treated):

DIABETES **HEART PROBLEM**

ASTHMA **SEIZURES**

HIV **KIDNEY PROBLEMS**

ARTHRITIS **LIVER DISEASE**

HIGH BLOOD PRESSURE

FAMILY MEDICAL HISTORY
(circle the following that have occurred in your family)

DIABETES **HEART DISEASE** **ARTHRITIS**
CANCER **BLEEDING DISORDERS**
HIGH BLOOD PRESSURE
OTHER______________________________

SOCIAL HISTORY
TOBACCO USE__________**ALCOHOL USE** __________
RECREATIONAL DRUG USE____________________

DO NOT WRITE IN THIS SPACE

FOR OFFICE USE ONLY

PLEASE LIST ANY OTHER SERIOUS MEDICAL PROBLEMS

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____
PATIENT OR GUARDIAN SIGNATURE

Great Neck Podiatry Associates

Dr. Marc Brenner Dr. Lance Greiff
Dr. Paul Koslow

INSURANCE INFORMATION

Primary Insurance Co:		
Policy or ID#:	Group#:	
Insured's Name:	Relationship to Pt: Self / Spouse / Parent	
Insured's Social Security #:	Insured's Date of Birth	Sex Male / Female
Secondary Insurance Co.:		
Policy orID#:	Group#:	
Insured's Name:	Relationship to Pt: Self / Spouse / Parent	
Insured's Social Security#:	Insured's Date of Birth	Sex Male / Female

SIGNATURE ON FILE

- I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS
- I AUTHORIZE RELEASE OF PERTINENT INFORMAION TO ALL MY INSURANCE COMPANIES
- I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL
- I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY.
- I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

Patient Name ______________________ SS# __________________

Signature ______________________ Date __________________

GREAT NECK PODIATRY ASSOCIATES
29 Barstow Road
Great Neck, NY 11021
(516)829-1028

Please take a few minutes to read the following information.
With today's insurance regulations constantly changing this can apply to you.

Please initial each line

_____ I understand that the initial visit may require x-rays in order to complete the examination, diagnosis and treatment plan. **Some plans do require an additional copay for x-rays.**

_____ I understand and agree that all co-pays, deductibles are due at the time of treatment.

_____ You may need written authorization from your **primary care physician** to be examined. I understand that it is **my responsibility to obtain this authorization and be aware of the number of visits allowed and the date of expiration.**

_____ You may need written authorization from your **primary care physician** for all follow up visits.

_____ You may need authorization from your primary care physician, this office or directly from your insurance company for any of the following procedures ordered by our doctors:

Physical Therapy, M.R.I., CT scan, Blood Tests, Bone Scan, etc.

_____ Most insurance companies **DO NOT** pay for durable soft goods applied in the office
For example: Orthotics, Splints, Air Casts, Braces, etc. Payment for these items is the responsibility of the **PATIENT.**

_____ If my insurance does not cover this treatment for any reason, I acknowledge and agree that I will be held responsible for the amount owed to Great Neck Podiatry, to be paid in full within 10 days of notice, unless there is another arrangement which is agreed upon.

_____ **LEGAL ASSIGNMENT:** The undersigned expressly agrees that if, upon default, this matter is referred to an attorney for collection, and the undersigned agrees to pay for any and all court cost, incurred therewith.

PRINT NAME_______________________________________ DATE________________

SIGNATURE_______________________________________

RESPONSIBLE PARTY_________________________________ (patient, spouse or guardian)

GREAT NECK PODIATRY ASSOCIATES
29 Barstow Road
Great Neck, NY 11021

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 of Authorized Representative (if applicable)

______________________________ Signature

Patient Request for Confidential Communication

Please fill out this form for any person that you would like us to speak to regarding your care. This will allow us to give this person(s) test results, communicate information from your office visit and other Protected Health Information. We **WILL NOT** release a copy of your medical record to this person(s) without your specific written request. This request may be revoked at any time, by written or verbal consent.

I,______________________ hereby request confidential communication of my protected information to the following individuals(s):

Communications with the patient named above can be directed to:

Name:______________________________

Address:______________________________

Phone:______________________________

Relationship to Patient:______________________________

Methods of Communication (Please Circle): Phone Mail

Patient Signature:______________________ Date__________

Date of birth:______________________