HUDSON PODIATRY ASSOCIATES, P.C.

Patient Name_____ DOB_____

Address_____

City_____ State_____ Zip_____

E-mail Address _____

Phone #_____ Cell #_____

Work #_____ Sex_____ Marital Status S M D W

Employer_____ Occupation_____

Referral Source _____

Primary Physician_____ Phone #_____

Pharmacy_____ Phone #_____

Emergency Contact _____ Phone #_____

INSURANCE INFORMATION

Primary Insurance_____ Policy ID #_____

Subscriber's name_____ DOB_____ Sex____ Relationship to patient_____

Does your insurance require a referral from your primary physician?_____

Secondary insurance coverage Yes No

Secondary Insurance_____ Policy ID#_____

Subscriber's name_____ DOB_____ Sex____ Relationship to patient_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with_____ and assign any insurance benefits for services rendered directly to Hudson Podiatry Associates, P.C. I authorize the release of any information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions. I accept responsibility for securing any required referral from my primary physician and further accept financial responsibility if services are rendered without such referral.

_____ _____

Signature of patient or guardian Date

HUDSON PODIATRY ASSOCIATES, P.C. / MEDICAL HISTORY

Name:_____ DOB: _____

Height: _____Weight: _____ Blood pressure: _____/_____

Have you had the flu vaccination this flu season? _____ Pneumococcal vaccination? _____

If you have not received the flu vaccination this flu season, it is recommended that you consult with your primary care physician.

Your current foot complaint:_____

	Yes	No
Have you been ill recently?		
Have you been hospitalized in the past three years?		
In the last year, have you been injured in a fall or fallen more than twice?		
High Cholesterol		
High Blood Pressure		
Diabetes ☐ TYPE I ☐ TYPE II		
Gout		
Lyme Disease		
Liver Disease, Jaundice or Mononucleosis		
Rheumatic Fever; Scarlet Fever; Mitral Valve Prolapse		
Thyroid Condition		
Severe infection or poor wound healing		
Prolonged bleeding problems		
Are you on blood thinners? eg: Aspirin, Coumadin, Plavix, Pradaxa or any other?		
Are you pregnant?		
Do you smoke? ☐ Current smoker ☐ Former smoker ☐ Never smoked		
Do you drink alcohol? ☐ Light ☐ Moderate ☐ Heavy		
Have you ever had any significant medical/surgical condition not noted on this form?		
Please list previous surgeries:		
Please list current medications:		
Please list allergies to any pills or medication:		
Are you allergic to latex, iodine, shellfish or any other foods?		
Relevant family medical history?		

Review of Systems (Please check the box if you currently have any of these symptoms/conditions or check "NONE"

Cardiovascular	☐ Leg pain when walking ☐ Leg swelling	☐ Fainting ☐ Fever ☐ Palpatations	☐ Chest pain/ pressure ☐ Vascular disease	☐ Valve problems ☐ Cold hands/feet	☐ **NONE**
Genitourinary	☐ Blood in urine ☐ Incontinence	☐ Hesitancy ☐ Excessive urination	☐ Decreased frequency ☐ Increased urgency	☐ Kidney stones ☐ Kidney disease	☐ **NONE**
Gastrointestinal	☐ Abdominal pain ☐ Diarrhea ☐ Constipation	☐ Heartburn ☐ Trouble swallowing	☐ Blood in stool ☐ Decrease appetite ☐ Increase appetite	☐ Vomiting ☐ Ulcers	☐ **NONE**
Integumentary	☐ Athletes foot	☐ Nail abnormalities	☐ Keloids (scars)	☐ Itchiness ☐ Dry, scaly skin	☐ **NONE**
Hematological	☐ Lower leg ulcers	☐ Sickle cell disease	☐ Anemia	☐ Blood thinners ☐ Clotting disorder	☐ **NONE**
Neurological	☐ Tingling ☐ Numbness	☐ Weakness ☐ Paralysis	☐ Seizures ☐ Tremors	☐ Headaches	☐ **NONE**
Musculoskeletal	☐ Neck pain ☐ Back pain ☐ Sciatica	☐ Joint pain ☐ Joint stiffness ☐ Joint swelling	☐ Joint instability ☐ Muscle weakness ☐ Muscle pain	☐ Arthritis	☐ **NONE**
Respiratory	☐ Chest pain ☐ Shortness of breath	☐ Wheezing ☐ Emphysema	☐ COPD ☐ TB ☐ Asthma	☐ Coughing ☐ Snoring	☐ **NONE**

_____ _____

Signature of patient or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hudson Podiatry Associates P.C. furnishes a Notice of Privacy Practices, illuminating the use/disclosure of healthcare information.

Statements regarding race, ethnicity and preferred language are deemed personal and not for dissemination, unless otherwise noted.

Signature of this form, done at the patient's discretion, acts as acknowledgment of its receipt.

This information is exempt from public reporting.

I may be contacted by mail, phones as listed on the encounter form and voicemail/answering machine unless otherwise declared. Internet based delivery reminders are not permitted. Messages may be left with my emergency contact as noted.

I acknowledge that I have received a Notice of Privacy Practices.

_____

Please print your name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

Written acknowledgement from this patient of receipt of the Notice of Privacy Practices could not be obtained because:

- o The patient refused to sign
- o Communication with the patient was not possible
- o An emergency situation arose
- o Other _____

_____

_____

_____ _____

Employee signature Date