

**HUDSON PODIATRY ASSOCIATES, P.C.**

**PATIENT UPDATE**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Preferred # for calls / voicemails:  Home  Cell 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: \_\_\_\_\_

Have you had the flu vaccination this flu season? \_\_\_\_ Pneumococcal vaccination? \_\_\_\_ COVID-19 vaccination? \_\_\_\_

**If you have not received the flu or COVID-19 vaccination, it is recommended that you consult with your primary care physician.**

Your current foot complaint: \_\_\_\_\_

Is your current foot complaint related to a work injury or auto accident? Yes      No

	Yes	No
Have you been ill recently?	Yes	No
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 <input type="checkbox"/> TYPE I <input type="checkbox"/> 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, Pradaxa, Elequis, Xarelto, Plavix or Effient?		
Are you pregnant?		
Do you smoke? <input type="checkbox"/> Current smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Never smoked		
Do you drink alcohol? <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> 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")**

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

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

Contact may be through mail, e-mail, and phone as listed on the encounter form as well as text messaging/voicemail/answering machine unless otherwise declared. Messages may be left with the emergency contact as noted.

Sharing of Advanced Directives with this organization is declined.

Signature of this form is acknowledgment of its receipt.  
This information is exempt from public reporting.

\_\_\_\_\_  
*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:

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

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date