

Practice:

Today's Date:

Name: _____ DOB: _____ Chart Number: _____

Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? Yes No

Insured Information

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

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

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

Other: _____

What is the reason for your visit today? _____

Result of accident or work injury? Yes No

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: _____

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: _____

Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

- Medical History:**
- | | | | | | |
|---|--|--|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Breathing issues | |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stomach/bowel | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Diabetes (type I, type 2) | | | |
| <input type="checkbox"/> Arthritis (specify) _____ | <input type="checkbox"/> other (specify) _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> CVA | | |
- Are you pregnant?** Yes No **Are you nursing?** Yes No Skin disorders Stroke

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

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

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

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

Family History

 Is there any family history (blood relative) of: (Please indicate family member)

- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Bleeding disorders _____ | <input type="checkbox"/> Emphysema _____ |
| <input type="checkbox"/> Blood clot _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Neurological _____ |
| <input type="checkbox"/> Circulation problems _____ | <input type="checkbox"/> Strokes _____ |
| <input type="checkbox"/> Other (specify): _____ | |

Review of Systems

 (Please check the box if you currently have any of these symptoms or check "NONE")

- | | | | | | | |
|-------------------------|--|--|--|--|---|---------------------------------------|
| Cardiovascular | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling | <input type="checkbox"/> cold hands/feet | |
| | <input type="checkbox"/> fainting | <input type="checkbox"/> palpitations | <input type="checkbox"/> vascular disease | <input type="checkbox"/> valve problems | <input type="checkbox"/> NONE | |
| Genitourinary | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hesitancy | <input type="checkbox"/> incontinence | <input type="checkbox"/> increased urgency | | |
| | <input type="checkbox"/> decreased frequency | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | <input type="checkbox"/> NONE | |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool | <input type="checkbox"/> vomiting | <input type="checkbox"/> ulcers | <input type="checkbox"/> constipation |
| | <input type="checkbox"/> diarrhea | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> decrease appetite | <input type="checkbox"/> increase appetite | <input type="checkbox"/> NONE | |
| Integumentary | <input type="checkbox"/> athlete's foot | <input type="checkbox"/> nail abnormalities | <input type="checkbox"/> keloids | <input type="checkbox"/> itchiness | <input type="checkbox"/> dry, scaly skin | <input type="checkbox"/> NONE |
| Hematologic | <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 disorders | <input type="checkbox"/> NONE |
| Neurological | <input type="checkbox"/> tingling | <input type="checkbox"/> weakness | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> headaches | |
| | <input type="checkbox"/> tremors | <input type="checkbox"/> paralysis | | | <input type="checkbox"/> NONE | |
| Musculoskeletal | <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain | <input type="checkbox"/> neck pain | |
| | <input type="checkbox"/> sciatica | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> joint pain | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis | <input type="checkbox"/> NONE |
| Respiratory | <input type="checkbox"/> chest pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> COPD | <input type="checkbox"/> coughing | <input type="checkbox"/> snoring | |
| | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> emphysema | | | <input type="checkbox"/> NONE | |

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: _____

Date: _____

Practice:

Today's Date:

Name: _____ **Chart #:** _____ **Date of birth:** _____

Race: _____ I prefer not to answer I do not know
 (White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ I prefer not to answer I do not know

Preferred Language: _____ I prefer not to answer

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

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other: _____

Name(s): _____

Smoking Status

Current Every Day Smoker Never Smoker

Current Some Day Smoker I decline to answer

Former Smoker

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** Yes No

PLEASE READ AND SIGN: The information on my intake form(s) 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. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

Yehuda Nezarria, D.P.M.

Podiatric Medicine and Surgery

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Rockville Centre, NY 11570
(516) 887-2820

595 Rt. 25A, Suite 5
Miller Place NY 11764
(631) 849-3330

I hereby authorize Dr. Yehuda Nezarria to release my medical records to any health care facility, insurance company, hospital or any other individual for the purpose of review, investigation or evaluation of any claim (s) submitted to the above entity.

In addition, I authorize Dr. Yehuda Nezarria to disclose to a hospital or to a health insurance plan any medical information obtained, if such disclosure is necessary for processing a claim.

This authorization shall come into effect immediately upon execution and shall remain in effect for the term of coverage with Dr. Yehuda Nezarria including a reasonable time thereafter.

I further understand that I will be responsible for any co-payments or any deductibles applied to the claim (s). In addition, I will be responsible to any portion or the whole amount of the claim (s) in the event that it is not covered by my insurance company (ies).

This authorization shall be binding upon me, my dependents or any entity acting in my behalf.

PATIENT NAME: (PRINT) _____

SIGNATURE: _____ DATE: _____

MEDICARE PART B

I request that payments of all authorized Medicare benefits due to me to be paid to Dr. Yehuda Nezarria for any services furnished to me by him. I authorize Dr. Nezarria to release to Health Care Financing Administration and/or its agents any material needed to determine these benefits or the benefits payable for related services.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

MALVERNE/ BELLMORE/ MILLER PLACE

PODIATRY CENTERS

ACKNOWLEDGMENT OF RECEIPT

OF

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 choose) and understood the Notice.

Patient Name (Please Print)

Date

Parent or Authorized Representative (if applicable)

Signature