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: Alcoholism | Blood disorders | Circulation problems | Musculoskeletal | Breathing issues | Liver | Sleep apnea | Gout | Allergies | Heart disease | Asthma | Heart murmur | Stomach/bowel | Depression | Anxiety disorder | Mental illness | Kidney disease | Blood clot | High cholesterol | High blood pressure | Cancer | Hepatitis

Neuropathy *(specify)* __________ Thyroid disease *(specify)* __________ Diabetes (type 1, type 2)

Arthritis *(specify)* __________ other *(specify)* __________ HIV 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)*

Alzheimer's	______________	Depression	______________
Arthritis	______________	Diabetes	______________
Bleeding disorders	______________	Emphysema	______________
Blood clot	______________	Heart disease	______________
Cancer	______________	High Blood Pressure	______________
Cataracts	______________	Neurological	______________
Circulation problems	______________	Strokes	______________
Other (specify):	______________		

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

Cardiovascular	leg pain when walking, fainting	fever, palpitations	chest pain/pressure, vascular disease	leg swelling, valve problems	cold hands/feet, **NONE**
Genitourinary	blood in urine, decreased frequency	hesitancy, excessive urination	incontinence, kidney disease	increased urgency, kidney stones	**NONE**
Gastrointestinal	abdominal pain, diarrhea	heartburn, blood in stool, trouble swallowing	vomiting, decrease appetite	ulcers, increase appetite	constipation, **NONE**
Integumentary	athletes foot	nail abnormalities, keloids	itchiness	dry, scaly skin	**NONE**
Hematologic	lower leg ulcers	sickle cell disease, anemia	blood thinners	clotting disorders	**NONE**
Neurological	tingling, tremors	weakness, paralysis	seizures	numbness	headaches, **NONE**
Musculoskeletal	back pain, sciatica	joint swelling, joint stiffness, joint pain	muscle weakness, joint instability	muscle pain, arthritis	neck pain, **NONE**
Respiratory	chest pain, shortness of breath	wheezing, emphysema	COPD	coughing	snoring, **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
Current Some Day Smoker
Former Smoker
Never Smoker
I decline to answer

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 Nezaria, D.P.M.

Podiatric Medicine and Surgery

2000 N. Village Ave., Suite 207
Rockville Centre, NY 11570
(516) 887-2820

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

I hereby authorize Dr. Yehuda Nezaria 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 Nezaria 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 Nezaria 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 Nezaria for any services furnished to me by him. I authorize Dr. Nezaria 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 & MILLER PLACE PODIATRY CENTERS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) ad understood the Notice.

____
Patient Name (Please Print)

____
Date

____
Parent or Authorized Representative
(if applicable)

____
Signature