MARLBORO PODIATRY CENTER **Date**_____

Patient's Name:_____ **Date of Birth:**_____ **Chart #**_____

Marital Status: ___Single ___ Married ___Partnered

Patient's Gender: Male Female ___Widowed ___Divorced

Address:_____ **City:**_____ **State**____ **Zip**_____

Telephone: **Home:**_____ **Cell:**_____ **Other:**_____

SS #_____ **E-Mail Address:**_____

Employer:_____ **Employer Tel #**_____

Employer Address:_____ **City**_____ **State**____ **Zip**_____

Person Responsible for Bill, if other than the patient:

Name: _____ **Relationship:** _____ **Phone #** _____

Address, if different from patient: _____

City: _____ **State:** _____ **Zip Code:** _____

Reason for Today's Visit

What is the Primary Reason for Today's Visit? _____

How Long Has This Been Bothering You? _____ days weeks months years

HOW DID YOU HEAR ABOUT OUR PRACTICE?

__Physician __Family Member __Friend ***Name of Referring Person***_____

__Internet ___Website __Facebook ***Other***_____

INSURANCE INFORMATION:

Primary Insurance: _____ **Is this a managed care Medicare (HMO): Yes No**

Are you the Policy Holder? __Yes __No

If the patient IS NOT the policy holder/subscriber, please provide the following:

Insured Information:

Subscriber Name: _____ Relationship: ___Spouse ___Child ___Other

Gender: __Male __Female Date of Birth: ___ /____/ _____

Secondary Insurance: _____ **Is this a managed care Medicare (HMO): Yes No**

If you are NOT the policy holder/subscriber, please provide the following:

Insured Information:

Subscriber Name: _____ Relationship: ___Self ___Spouse ___Child ___Other

Gender: __Male __Female Date of Birth: ___ /____/ _____

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 related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____

Signature of patient or representative Print Name Date

Medical History

Please Circle if You Have Had Any of the Following:

AIDS/HIV
Allergy to Anesthetic
Anemia
Angina
Arthritis
Artificial Heart/Valve/Joint
Asthma
Back Problems
Bladder Problems
Bleeding Disorders
Cancer, Type: _____
Chemical Dependency
Chest Pain
Cholesterol: High or Low
Chronic Diarrhea
Circulatory Problems
Diabetes, Type: _____
Ear Problems
Epilepsy
Eye Problem
Fainting
Frequent Infections
Gout
Headaches
Hearing Problems
Heart Disease
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
Immune Disorders
Kidney Problems
Liver Disease
Low Blood Pressure
Neurological
Neuropathy
Phlebitis
Psychiatric Care
Radiation Treatment
Rash
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Sinus Problems
Skin Cancer
Special Diet
Stroke
Swelling in Ankles, Feet
Swollen Neck/Glands
Thyroid: Hypothyroid or Hyperthyroid
Tired Feet
Tuberculosis
Ulcers - Stomach, Other:_____
Varicose Veins
Venereal Disease
Weight Loss, unexplained
OTHER_____
_____

Review of Systems: *If any of the following apply to you, please check off*

Cardiovascular:	__fever	__fainting	__ chest pain/pressure	__ leg swelling	__ cold hands/feet
	__ leg pain while walking	__ heart palpitations	__ vascular disease	__ valve problems	__ None
Ears/Nose/Throat:	__ sinus problems	__ polyps	__ deafness		__ None
Endocrine:	__ diabetes	__ thyroid problems			__ None
Eyes:	__ cataracts	__ glaucoma	__ blindness		__ None
Gastrointestinal:	__ abdominal pain	__ increased appetite	__ heartburn	__ vomiting	__ blood in stool
	__ trouble swallowing	__ decreased appetite	__ diarrhea	__ ulcer	__ constipation __None
Genitourinary:	__ blood in urine	__ hesitancy	__ incontinence	__ increased urgency	
	__ decreased frequency	__ excessive urination	__ kidney disease	__ kidney stones	__ None
Hematologic:	__ lower leg ulcers	__ clotting disorders	__ blood thinners	__ anemia	__ sickle cell __ None
Integumentary:	__ nail abnormalities	__ athlete's foot	__ dry, scaly skin	__ itchiness	__ keloids __ None
Musculoskeletal:	__ joint swelling	__ muscle weakness	__ muscle pain	__ back pain	__ neck pain
	__ joint stiffness	__ joint instability	__ joint pain	__ sciatica	__ arthritis __None
Neurological:	__ tingling	__ weakness	__ seizures	__ numbness	
	__ headaches	__ tremors	__ paralysis		__ None
Respiratory:	__ chest pain	__ wheezing	__ COPD	__ coughing	__ snoring
	__ emphysema	__ shortness of breath			__ 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 related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

PODIATRIC HISTORY:

Have you been to a Podiatrist before? ___ yes ___ no

If yes:

When did you last see a Podiatrist? _____

What was the Problem you were treated for? _____

What is your Shoe Size _____

SURGICAL HISTORY

Please Provide Your Surgical History:

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Do You Smoke ___Yes __No If yes how many packs per day ____ For How Long _____

Alcohol Use ___Yes everyday (5-7 days/week) __Yes Occasionally/socially __Rarely __ None

Substance Abuse ___No, I have never had a substance abuse problem.
___Yes, I have a current substance abuse problem.
Please Specify: _____

Occupation: _____Does it involve mostly __standing __sitting

Exercise: ____ I do not exercise regularly ____Yes, I do the following regular exercise:

_____

Family History:

PLEASE INDICATE THE FAMILY MEMBER THAT THE CONDITION APPLIES TO
(EX. FATHER, MOTHER, BROTHER, SISTER, ETC.)

___Alzheimer's _____
___Arthritis _____
___Bleeding disorders _____
___Blood clot _____
___Cancer _____
___Cataracts _____
___Circulation Problems _____
___Other (please specify_____

___Depression _____
___Diabetes _____
___Emphysema _____
___Heart Disease _____
___High Blood Pressure _____
___Neurological _____
___Strokes _____
___ Other (please specify) _____

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 related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

Practice: MARLBORO PODIATRY CENTER **Today's Date:**

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

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: English ☐Declined to specify

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 Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

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: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Did you get a pneumococcal vaccination? ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Advanced Directives: ☐ Living Will ☐ DNR ☐ Durable Power of Attorney ☐ Surrogate Appointed ☐ None

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: _____

MARLBORO PODIATRY CENTER

HIPAA
Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our Notice of our Privacy Practices:

Print Name:_____ Date of Birth: _____

Signature:_____ Date: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #:_____ Cell #:_____ Work #:_____ Ext:_____

I authorize Brief messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize Extended messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize secure electronic communications be sent to my email address at: _____

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Restrictions: _____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Restrictions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, Marlboro Podiatry Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name:_____ Date:_____

Signature:_____ Relationship: _____

Additional Authorizations

Emergency Contact:_____ Relationship:_____ Phone:_____

CONTINUED ON REVERSE SIDE

Patient's Name: **DOB:**

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility Form

Thank you for choosing our practice, Marlboro Podiatry Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, Marlboro Podiatry Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, Marlboro Podiatry Center.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-Prescription Consent for Medication History

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards (**Visa, Mastercard, or Discover**).
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, Marlboro Podiatry Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, Marlboro Podiatry Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian **Date**

CONTINUED ON REVERSE SIDE