WELCOME TO OUR OFFICE!

Date _____

PATIENT INFORMATION

Name _____

Nickname _____ Sex: Male / Female

Birth Date _____ Age _____

Marital Status:
Single / Married / Divorced / Widowed

Social Security # _____

Address _____

City / State _____ Zip _____

Home Phone _____

Work Phone _____

Best Time / Place to call _____

Email _____

Occupation _____

Employer _____

Address _____

City / State _____ Zip _____

Employer Phone _____

How did you hear about our office?

Yellow Pages / Website / Family
Friend / Physician / Insurance Plan

Other: _____

We would like to thank them!

Name _____

Address _____

City / State _____ Zip _____

INSURANCE

Insured Name _____

Relationship to Patient _____

Insured Birth Date _____

Is this patient covered by additional insurance?
YES **NO**

MEDICATIONS

List all medications you are currently taking including over-the-counter products, vitamins, and herbals.

_____

_____

_____

_____

Pharmacy Name _____

ALLERGIES

Have you ever experienced any **ALLERGIES** or **ADVERSE EFFECTS** to any of the following?

	YES	**NO**
Adhesives / Tape	❑	❑
Aspirin	❑	❑
Anti-Inflammatories	❑	❑
Codeine	❑	❑
Iodine (IVP dye)	❑	❑
Local Anesthetics (Novocaine / Lidocaine)	❑	❑
Penicillin	❑	❑
Sulfa Drugs	❑	❑

OTHER: _____

_____

MEDICAL HISTORY Please check "YES" or "NO" to indicate if you have had any of the following:

	YES	NO		YES	NO
AIDS / HIV	❑	❑	Hepatitis	❑	❑
Arthritis	❑	❑	High Blood Pressure	❑	❑
Asthma	❑	❑	High Cholesterol	❑	❑
Back Problems	❑	❑	Kidney Problems	❑	❑
Blood Clots	❑	❑	Liver Problems	❑	❑
Cancer	❑	❑	Parkinson's Disease	❑	❑
Diabetes	❑	❑	Psychiatric Problems	❑	❑
Epilepsy	❑	❑	Stomach Ulcers	❑	❑
Eye Problems	❑	❑	Stroke	❑	❑
Foot / Leg Cramps	❑	❑	Thyroid Problems	❑	❑
Gout	❑	❑	Are you a smoker?	❑	❑

OTHER: _____

Please **list all surgeries** and approximate dates _____

_____

_____

DIABETICS: Please answer the following questions:

How many years have you been diagnosed as a diabetic? _____

Blood Sugar Checks: How many times each day? _____ Average reading? _____

FOOT HEALTH INFORMATION

What is your current foot problem? _____

When did it begin? _____

How have you treated this problem so far? _____

Have you seen another doctor for this problem? _____ If so, whom? _____

Have you ever seen a foot doctor? _____ If so, whom? _____

Shoe size _____ Height _____ Weight _____

Who is your **Primary Care Physician**? _____ Date of Last Visit _____

Physician's Address _____ Phone: _____

Are you under regular care for any specific problem? _____

In case of emergency, contact Name: _____ Phone: _____

NORTH ROCKLAND PODIATRY

Peter Costa, D.P.M., F.A.C.F.A.S.
7 Liberty Square
Stony Point, NY 10980
Telephone: 845.429.0520//Fax: 845.429.0603

ACKNOWLEDGEMENT 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 chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Who else can receive results or any other information for above patient?:

Name:	Phone Number:
1.	
2.	
3.	

North Rockland Podiatry

Peter Costa, D.P.M., F.A.C.F.A.S

7 Liberty Square Mall
Stony Point, NY 10980
Phone: 845-429-0520

Our Office Policies:

- ☐ All copays are due at time services are rendered. If you cannot pay your co-pay at the time of the visit, please talk to the receptionist before being seen by the doctor. We accept cash, check, Visa, MasterCard and Discover. Please make all checks payable to: **NORTH ROCKLAND PODIATRY, P.C.**

- ☐ For *all* **follow up** visits **you will be charged a copay** (if required by your insurance company). This includes orthotic dispensing/orthotic checks and post-operative visits.

- ☐ If you have Insurance we do not participate with or you have no Insurance coverage, payment is due at the time of service.

- ☐ If your Insurance plan requires a referral, you must present it at the time of your visit. **It is the patient's responsibility to get referrals if they are needed.** If you come to your appointment without a valid referral YOU will either be rescheduled or charged for the visit.

- ☐ If you do not inform us of any special requirements with your contract and we order services (lab work, x-rays, etc.) and these services are not covered our office will bill the patient.

- ☐ Any fees or services provided during a period where your coverage is not in effect, all fees submitted and denied will be the patient's responsibility.

- ☐ Appointments that are missed without any notification will have a charge of $25.00 placed on account. A Charge of $75.00 will be placed on account for a missed in-office surgical procedure. A charge of $20.00 will be placed on account for returned checks.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND I AGREE TO ACCEPT PERSONAL RESPONSIBILITY AS DESCRIBED.

Signature:_____ **Date:**_____