PATIENT INFORMATION (Please Print)

Patient Name ___________________________________DOB ________________Age________________

Home
Address:_________________________________City:_______________State:_______Zip:____________

Home Phone: _________________________Cell:____________________Work Phone:________________

- Please check to receive text message reminders

Male:____Female____Marital Status: S____M____W____D__ Shoe Size:______Weight:_______Height:_______

Employer:_________________________________Social Security #______________________________

Email Address:____

◯ Please check if we may use your email for reminders, communication and updates about our office.

Emergency Contact: ________________________________Phone #:_____________________________

Guarantor Name: _____________________________DOB___________Guarantor Phone #:_____________

Guarantor Employed By:_________________________Work Phone________________SSN:____________

How did you find out about our office?

Name:_____________________________Address:____

MEDICAL INFORMATION

Family Doctor_________________________Ph#:_________________Date of Last Visit_________________

Pharmacy Name:________________________________Pharmacy Phone #_________________________

Please describe your foot/ankle problem and how long you've had it:

____

List all Allergies____

____

List all medications including over the counter and herbal supplements:

____

____

____

____

Have you had any serious illness or operation? Yes_______ No_______ Explain:________________________

____

List surgeries and dates:____

____

Do you smoke: Yes No In the past: Yes No Packs per day_____________Quit Date_______________

Do you drink alcohol? Yes No Drinks per week____

Family History of specific illness:____

____

PLEASE MARK ANY CONDITION WHICH PERTAINS TO YOU:

☐ Anemia	☐ Circulation	☐ Hepatitis	☐ Osteoporosis
☐ Arthritis	☐ Dementia	☐ High Blood Pressure	☐ Recurrent Infections
☐ Asthma	☐ Depression	☐ High Cholesterol	☐ Skin Condition
☐ Autoimmune Disorder	☐ Diabetes	☐ HIV/Aids	☐ Stomach Problem
☐ Bleeding Tendency	☐ Fibromyalgia	☐ Hypothyroidism	☐ Stroke
☐ Blood Clots	☐ Gastric Ulcers	☐ Kidney Disease	☐ Tuberculosis
☐ Cancer	☐ Gout	☐ Liver Trouble	☐ Varicose Veins
☐ Chronic Back Pain	☐ Healing Problems	☐ Lung Disease	
	☐ Heart Disease		

REVIEW OF SYSTEMS

Please circle YES or NO to indicate if you currently have any problems in one of more of the following areas. If yes, please explain or describe the problem:

General/Constitutional (fever, weight loss or gain, tired feeling)__________________________________ YES NO

Eyes (blurred vision, eye pain, discharge, etc)____YES NO

Ears, Nose, Throat, Mouth (hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc)____YES NO

Respiratory (asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc______________YES NO

Cardiovascular (hypertension, heart problems)____YES NO

Gastrointestinal (diarrhea, constipation, hernia, ulcers, etc)____YES NO

Genitourinary (painful urination, frequent urination, impotence, etc)_________________________________YES NO

Lymphatic (anemia, bleeding problems, problems with blood transfusions, etc)________________________YES NO

Endocrinology (hypothyroidism, diabetes mellitus) ____YES NO

Musculoskeletal (arthritis, joint pain, swelling, cramps, stiffness)____________________________________YES NO

Skin (pimples, warts, growths, rashes, etc)____YES NO

REFERRAL AND NON-COVERED FOOT CARE

If your insurance is a part of a Managed Care plan (HMO, POS, EPO, etc), failure to obtain a valid referral from your primary care physician (PCP) may result in reduced or non-payment of benefits.

Your insurance carrier may determine that your foot care is an excluded service, in which no reimbursement will be made. Should this occur, the responsibility of payment for these services, will remain yours. This includes orthotics, splints, over the counter medications, heel cups, pads, toe separators, or any other equipment received that insurance carrier may not pay.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I acknowledge responsibility for payment of any deductibles, co-insurance and unauthorized or non-covered services. I accept responsibility for any unpaid bills sixty days after insurance is filed. If for any reason the account becomes delinquent, I agree to pay for all collection and legal fees. In case of default payment, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs. I authorize Keith Naftulin, DPM, PC, to act as my agent in helping me obtain payment from my insurance company. I request payment of my insurance benefits to be made directly to Keith Naftulin, DPM, PC for any services furnished to me by that physician. I permit a copy of this authorization to be used in place of the original. I hereby give permission to Keith Naftulin, DPM, PC to examine and administer treatment after consultation and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Keith Naftulin, DPM, PC and that I have read and understand the Notice.

Signature of Patient or Legal Representative____Date:__________