Practice: **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

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

Spouse/Partner Name: _____ **E-mail:** _____

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

Home #: _____ **Cell #:** _____ **Work #:** _____

Pharmacy: _____ **Phone:** _____

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

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Policy ID: _____

Insured Information

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

Address: _____

Group ID: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Phone #: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Policy ID: _____

Insured Information

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

Address: _____

Group ID: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Phone #: _____

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

What is the reason for your visit today? _____

_____

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:_____

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._____ _____

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 ☐ Diabetes (type 1, type 2)
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Skin disorders *(specify)* _____
☐ Arthritis *(specify)* _____ ☐ Other *(specify)* _____
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Surgical History ☐ None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass Surgery ☐Cataract Surgery ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body?
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? ☐ Yes, I do the following regular exercise: _____
☐ No, I do not exercise regularly

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*
☐ Arthritis ☐ Cancer ☐ High Blood Pressure ☐ Bleeding disorders ☐ Circulation problems ☐ Strokes
☐ Hammer toes ☐ Blood clot ☐ Diabetes ☐ Heart disease ☐ Neurological
☐ Other (specify):_____

Current Medications ☐None ☐ I take the following Prescription or over the counter medications:
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Name: _____ Dose _____ How often? _____
Use the back of this form if more room is needed

Allergy ☐ No Known Allergies	**Reaction**
☐ Penicillin	
☐ Shellfish	
☐ Sulfa	
☐ Tape	
☐ Latex	
☐ Betadine *(iodine)*	
☐ Aspirin	
☐ Tylenol™	
☐ Ibuprofen	
☐ Codeine	
☐ Other *(specify)*_____	

Review of Systems *(Please check the box if you currently have any of these symptoms)*

Cardiovascular	☐leg pain when walking	☐fever	☐ chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐ palpitations	☐vascular disease	☐Valve Problems	
Genitourinary	☐blood in urine	☐hesitancy	☐incontinence	☐increased urgency	
	☐decreased frequency	☐excessive urination	☐kidney disease	☐kidney stones	
Gastrointestinal	☐abdominal pain	☐heartburn	☐blood in stool	☐vomiting	☐ulcers
	☐diarrhea	☐trouble swallowing	☐constipation	☐increase appetite	☐decrease appetite
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			

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

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: _____

Patient Financial Policy

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept cash or checks.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to "not be covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify befits for some specialized services or referrals however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. All costs incurred, including but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- **FAILURE TO CANCEL APPOINTMENTS WITHIN 24 HOUR, WILL RESULT IN A $20 FEE.**

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

DR. SHANNON ROESCH, DPM
Medicine and Surgery of the Foot
242 Jericho Turnpike
Floral Park, New York 11001
516-488-6290 (O) 516-488-3172 (F)
dr. roesch@yahoo.com (E)

Privacy Officer: Dr. Shannon Roesch

Effective Date April 14, 2003

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice.

New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice.

Who will Follow This Notice

Any healthcare professional authorized to enter the information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates(e.g. a billing service) sites, and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses and disclosures. Not every possible use or disclosure in a category is listed.

For Treatment

We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for your treatment process.

For payment

We may use medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example; We may need to send your protected health information, such as you name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations

We may use and disclose medical information about you for health care operations to assure that you receive quality healthcare. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

*As required during an investigation by law enforcement agencies
* To avert a serious threat to public health or safety
*As required by military command authorities for their medical records
* To worker's compensation or similar programs for processing of claims
*If an inmate, to the correctional institution or law enforcement official
*In response to a legal proceeding
*To a coroner or medical examiner for identification of a body
*As required by the US Food and Drug Administration (FDA)
*Other healthcare providers' treatment activities
*Other covered entities' and providers' payment activities
*Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
*Uses and disclosures required by law
*Uses and disclosures in domestic violence or neglect situations
*Health oversight activities
*Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

DR. SHANNON ROESCH, DPM
Medicine and Surgery of the Foot
242 Jericho Turnpike
Floral Park, New York 11001
516-488-6290 (O) 516-488-3172 (F)
dr. roesch@yahoo.com (E)

ACKNOWLEDGEMENT 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> and understood the notice.

_____
Name

_____
Parent or authorized representative