



# Welcome

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

### MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to \_\_\_\_\_  
Name of \_\_\_\_\_  
Doctor or Clinic for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Please print name of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Beneficiary \_\_\_\_\_

## PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been to a Podiatrist before?  
 Yes  No

If yes, please list.

Name \_\_\_\_\_

Last visit \_\_\_\_\_

Is there any personal or family history of diabetes?  
 Yes  No

Your occupation \_\_\_\_\_

Cigarette/Tobacco use \_\_\_\_\_

Years smoked \_\_\_\_\_

Athletic activities in which you participate (please list and indicate frequency)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate which foot problems you now have or have had in the past.

|                                    |                              |                             |
|------------------------------------|------------------------------|-----------------------------|
| Ankle Pain                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Athlete's Foot                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bunions                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Corns and Calluses                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cramps or Numbness in Feet or Legs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Flat Feet                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Foot or Leg Cramps                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heel Pain                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ingrown Toenails                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Plantar Warts                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in Ankles or Feet         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tired Feet                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |  |  |   |
|--|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No                          | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No              | Rash <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| Allergies to Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No          | Eye Problems <input type="checkbox"/> Yes <input type="checkbox"/> No          | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Allergies to Medicine or Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No    | Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No              | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No                            | Foot or Leg Cramps <input type="checkbox"/> Yes <input type="checkbox"/> No    | Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No                            | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Sinus Problems <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No                         | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No             | Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Artificial Heart Valves or Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No         | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No                            | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Swelling in Ankles, Feet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No                     | Hepatitis or Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No                | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No   | Tired Feet <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No                            | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No       | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No               | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No         | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No                        | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No    | Varicose Veins <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Chronic Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Neuropathy <input type="checkbox"/> Yes <input type="checkbox"/> No            | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No              | Phlebitis <input type="checkbox"/> Yes <input type="checkbox"/> No             | Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No                          | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No      |   |
| Ear Problems <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |

Surgeries you have had \_\_\_\_\_

Hospitalization other than for the surgeries listed \_\_\_\_\_

Family physician \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years?  Yes  No

If yes, please explain \_\_\_\_\_

### MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) (\_\_\_\_\_) \_\_\_\_\_

Do you take oral contraceptives?  Yes  No

### ALLERGIES

- |  |  |
|--|--|
| <input type="checkbox"/> Adhesive/Tape         | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine         |
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> Penicillin        |
| <input type="checkbox"/> Codeine               | <input type="checkbox"/> Seafoods          |
| <input type="checkbox"/> Demerol               | <input type="checkbox"/> Sulfa             |
| <input type="checkbox"/> Iodine                |  |
| Other _____                                    |  |

## TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient



# LONG ISLAND PODIATRY GROUP, P.C.

## MEDICINE AND SURGERY OF THE FOOT

*Board Certified by the American Board of Podiatric Surgery  
Fellows, American College of Foot Surgeons  
Members, American Association of Diabetes Educators  
www.LIpodgrp.com*

**Mary Ann Bilotti, D.P.M.**  
**Russell Caprioli, D.P.M.**  
**John G. Haight, D.P.M.**  
**Hugh L. Richardson, D.P.M.**  
**Marzana Mleczo, D.P.M.**

375 North Central Ave  
Valley Stream, NY 11580  
Telephone (516) 825-4070  
Fax (516) 825-1508

2001 Marcus Avenue, Ste. N8  
Lake Success, NY 11042  
Telephone (516) 327-0074  
Fax (516) 327-0083

### OFFICE CONTRACT

It is a great honor and privilege to have you as a patient in our office. In order to accommodate you effectively there are certain responsibilities you have to uphold as a compliant patient:

1. Present all insurance documents to our staff.
2. It is your responsibility to know your insurance policy as far as referrals, copay, and coverage.
3. If a referral is needed, it is your responsibility to obtain the referral prior to the office visit. If you do not have the referral at the time of the appointment, YOU CAN NOT BE SEEN. It is your responsibility to follow up with your medical doctor prior to the appointment to make sure your referral has been initiated by their office.
4. If you need to cancel or reschedule an appointment, our office requires the courtesy of a 24 hour notification. If you do not give us this courtesy call you will be charged a \$25.00 fee.

### APPOINTMENT TIMES ARE EXTREMELY VALUABLE TO OUR PATIENTS

5. Any appliances dispensed to you from this office must be approved by your insurance company. PLEASE BE AWARE THAT INSURANCE APPROVAL DOES NOT GUARANTEE PAYMENT TO THE DOCTOR. It is your responsibility to know if approval has been obtained. You are ultimately responsible for appliances such as orthotics, cam walkers, braces and shoes that insurance companies may not approve. The majority of the appliances are custom made and CAN NOT be returned. Once the items leave this office, you are responsible for payment. Your credit card information will be taken as a guarantee for our payment. Once payment has been received from your insurance company, you will receive a refund.

I have read and understand the office policy of Long Island Podiatry Group, P.C. It is my responsibility to abide by the rules and regulations and agree to the above office policies.

X \_\_\_\_\_

Date \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

|       |           |         |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|