**Practice:** EAST PATCHOGUE PODIATRY P. DBA SFAA **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:** _____ ☐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: _____

Name: _____

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: _____

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: _____

## 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 ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
**Are you pregnant?** ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

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

**Family History** Is there any family history *(blood relative)* of: *(Please indicate family member)*

| | | | |
|---|---|---|---|
| ☐ Alzheimer's | _____ | ☐ Depression | _____ |
| ☐ Arthritis | _____ | ☐ Diabetes | _____ |
| ☐ Bleeding disorders | _____ | ☐ Emphysema | _____ |
| ☐ Blood clot | _____ | ☐ Heart disease | _____ |
| ☐ Cancer | _____ | ☐ High Blood Pressure | _____ |
| ☐ Cataracts | _____ | ☐ Neurological | _____ |
| ☐ Circulation problems | _____ | ☐ Strokes | _____ |
| ☐ Other (specify): | _____ | | |

**Review of Systems** *(Please check the box if you currently have any of these symptoms or check "NONE")*

| | | | | | |
|---|---|---|---|---|---|
| **Cardiovascular** | ☐leg pain when walking | ☐fever | ☐ chest pain/pressure | ☐leg swelling | ☐cold hands/feet |
| | ☐fainting | ☐ palpitations | ☐vascular disease | ☐valve problems | ☐**NONE** |
| **Genitourinary** | ☐blood in urine | ☐hesitancy | ☐incontinence | ☐increased urgency | |
| | ☐decreased frequency | ☐excessive urination | ☐kidney disease | ☐kidney stones | ☐**NONE** |
| **Gastrointestinal** | ☐abdominal pain | ☐heartburn | ☐blood in stool ☐vomiting | ☐ulcers | ☐constipation |
| | ☐diarrhea | ☐trouble swallowing | ☐decrease appetite | ☐increase appetite | ☐**NONE** |
| **Integumentary** | ☐athletes foot | ☐nail abnormalities | ☐keloids ☐itchiness | ☐dry, scaly skin | ☐**NONE** |
| **Hematologic** | ☐lower leg ulcers | ☐sickle cell disease | ☐anemia ☐blood thinners | ☐clotting disorders | ☐**NONE** |
| **Neurological** | ☐dingling | ☐weakness | ☐seizures | ☐numbness | ☐headaches |
| | ☐tremors | ☐paralysis | | | ☐**NONE** |
| **Musculoskeletal** | ☐back pain | ☐joint swelling | ☐muscle weakness | ☐muscle pain | ☐neck pain |
| | ☐sciatica | ☐joint stiffness | ☐joint pain ☐joint instability | ☐arthritis | ☐**NONE** |
| **Respiratory** | ☐chest pain | ☐wheezing | ☐COPD | ☐coughing | ☐snoring |
| | ☐shortness of breath | ☐emphysema | | | ☐**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 listed above.

Patient Signature: _____ Date: _____

**Practice: EAST PATCHOGUE PODIATRY P. DBA SFAA** **Today's Date:**

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

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

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

*E-mail newsletters, reminders, statements, etc.* **Emergency Name:** _____ **Phone:** _____

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

**Home #:** _____ **Cell #:** _____ **Other #:** _____

**Employer:** _____ **Phone:** _____

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

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

***Insured Information***

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

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

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

***Insured Information***

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

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

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

**What is the reason for your visit today?** _____

_____ **Result of accident or work injury?** ☐Yes ☐No

**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: _____

**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 listed above.

Patient Signature: _____ Date: _____

Rev 6/5/2012

Suffolk Foot & Ankle
Board Certified Foot & Ankle Surgeons
Edward C. Kormylo, DPM, FACFAS
Kristina Karlic, DPM, FACFAS
Sara El Bashir, DPM, FACFAS
Joseph Zehentner, DPM, AACFAS
Sandra Zawadka, DPM, AACFAS

| | | |
|---|---|---|
| 285 Sills Road, Building 17, East Patchogue, NY 11772 | Phone: (631) 654-5566 | Fax: (631) 654-8250 |
| 976 Roanoke Avenue, Riverhead, NY 11901 | Phone: (631) 381-0201 | Fax: (631) 381-0203 |
| 1641 Route 112, Suite A, Medford, NY 11763 | Phone: (631) 447-0800 | Fax: (631) 447-0801 |
| 283 Commack Road, Suite 125, Commack, NY 11725 | Phone: (631) 499-3505 | Fax: (631) 499-5421 |
| 2112 Middle Country Rd, Centereach, NY 11720 | Phone: (631) 993-8100 | Fax: (631) 654-8250 |


## Patient Financial Policy

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

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- 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 time, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other 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 copay/coinsurance/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 payments 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 be not covered, or you do not have an authorization, you will be responsible for the complete charge.
- You must inform the office of all insurance charges and authorization/referral requirements. In the event the office is not informed, you will be responsible for the 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 prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the 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 at this office.
- There is a service fee for $35.00 for all returned checks. This is not covered by your insurance company.

Signature of Patient/Responsible Party: _____ Date: _____

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

Email Address: _____ Witness: _____