Practice of Podiatric Medicine and Surgery
91 Montgomery Street, Rhinebeck, NY 12572 and
Summerlin Plaza, 946 Route 376, Suite 11, Wappingers Falls, NY 12590
Office: (845) 876-8637 Fax: (845) 876-0218
www.rhinebeckfootcare.com

PATIENT INFORMATION					
Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		**Age:**
Soc. Sec. #:					
Street Address:		**City:**		**ST:**	**Zip:**
Home Phone:		**Cell Phone:**		**Work Phone:**	
Preferred Language: ☐ English ☐ Spanish	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Native Hawaiian/Other Pacific Island	**Race:** ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian/Other Pacific Island			
Communication Preference: ☐ Email ☐ Postal ☐ Telephone	**Referred by:** ☐ Patient ☐ Doctor ☐ Insurance	**Ref. Doctor Name: or Patient Name:**			
Email address:					
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed					
Occupation:		**Employer:**			
Emergency Contact:		**Phone:**			
Primary Care Physician:		**Phone:**			
Date of last visit to Physician:		**Preferred Pharmacy:**			
Sports/Activities:					

INSURANCE INFORMATION					
Is this Patient under 18 years of Age? ☐ Yes ☐ No	If yes, please complete the Person responsible for bill section				
Person responsible for bill	**Date of Birth** / /	**Address (if different):**		**Home phone no.** ( )	
Is this person a patient here? ❑ Yes ❑ No If yes, indicate patients name:					
Primary Insurance Carrier Name:					
Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:** / /	***Group no.:***	***Policy no.:***	***Co-payment:*** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary Insurance Carrier Name:					
Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:** / /	***Group no.:***	***Policy no.:***	***Co-payment:*** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

CONCERNING INSURANCE

Patients who are a member of a plan with which we participate are responsible at the time of service for all co-pays, deductibles and non-covered services and materials. Patients who are members of a plan which this office does not participate are fully responsible for all procedures and materials at the time of service. Medicare patients are responsible for non-covered materials, charges applied to their deductible and 20% of the office fees once the deductible has been satisfied. Secondary insurances will be billed if provided.

I have read the above and fully understand my financial responsibilities for all services and materials received in this office.

Signature:	**Printed Name:**	**Date:**

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Please describe your foot problem:			
Have you had any previous foot care or surgery?	☐ No ☐ Yes	If Yes, by whom:	

Current Age	Height	Weight	Shoe Size

PLEASE CHECK ANY OF THE FOLLOWING, WHICH YOU HAVE BEEN TREATED OR ARE BEING TREATED FOR

☐	Amputation	☐	Hepatitis	☐	Osteoporosis
☐	Anemia	☐	Hemophilia (bleeder)	☐	Phlebitis (Blood Clots)
☐	Anxiety Disorders	☐	High Cholesterol	☐	Polio
☐	Arthritis	☐	HIV	☐	Respiratory Condition
☐	Asthma	☐	Hypertension (high blood pressure)	☐	Scarlet Fever
☐	Cardiac Disease	☐	Keloid Former	☐	Sexually Transmitted Disease
☐	Cancer	☐	Kidney Disease	☐	Stroke
☐	Circulation Problems	☐	Kidney Stones	☐	Slow to heal
☐	Diabetes Type I	☐	Liver Disease	☐	Thyroid Disease
☐	Diabetes Type II	☐	Lyme Disease	☐	Tuberculosis
☐	Epilepsy	☐	Migraine Headaches	☐	Varicose Veins
☐	Gastrointestinal Problems	☐	Mitral Valve Prolapse		
☐	Glaucoma	☐	Muscular Disease		
☐	Gout	☐	Nervous System Disorder		
☐	Other:				

Female Patients, are you Pregnant:	☐ No ☐ Yes	If "Yes" Due Date:	/ /

AUTHORIZING AND RELEASE

- I consent and authorize release of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA), and if requested, will be given a copy of such notice.
- I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services rendered to me, or my child.
- I request that payment of authorized Medicare benefits be made on my behalf to Rhinebeck Foot Care for services furnished to me by the provider.
- I authorize any holder of medical information about me to release it as necessary to the Centers for Medicare and Medicaid Services, its agents, and private insurances to determine these benefits or the benefits payable for related services.
- I certify that the above information is correct and I consent to diagnostic procedures including but not limited to X-ray, medical care, and treatment as deemed necessary by Rhinebeck Foot Care.
- I authorize Rhinebeck Foot Care to take medical photographs for charting and educational purposes.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE

Patient Signature:		Date:	
Parent/Guardian:		Date:	

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MEDICATIONS (Including Vitamins and Dosages)					
Name		Dosage	Name		Dosage
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

MEDICATION ALLERGIES/REACTIONS			
Description		Description	
1.		5.	
2.		6.	
3.		7.	
4.		8	

PERSONAL SOCIAL HISTORY							
Alcohol:	☐ No ☐ Yes	If "Yes" Amount Per Week:		Caffeine:	☐ No ☐ Yes	If "Yes" Cups per day:	
Tobacco:	Never a Smoker: ☐	Former Smoker: ☐	Years quit:				
	☐ Current every day smoker	Packs per day:		How many years:			
	☐ Current occasional smoker	Packs per day:		How many years:			
Activities:				Exercise:			

PREVIOUS SURGERIES OR HOSPITALIZATIONS					
Description		Date	Description		Date
1.		/ /	5.		/ /
2.		/ /	6.		/ /
3.		/ /	7.		/ /
4.		/ /	8.		/ /

Reviewed and final completion by:		Date:	/ /

MEDICAL SUPPLIES			
I acknowledge that this office distributes miscellaneous medical "over-the-counter" type supplies and physician dispensed medications that are not covered by insurances but are available for purchase on a cash pay basis. I further acknowledge that this office will not bill the private insurance companies for these purchased items.			
Date:	/ /	Signature:	

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Patients Name:				**DOB:**			
Other Name:							
Street Address:		**City:**		**ST:**		**Zip:**	
Phone:		**SS#**					

I authorize Rhinebeck Foot Care to RELEASE my protected health information (PHI) to:

Name:		**Name:**	
Address:		**Address:**	
Phone #		**Phone #**	

I authorize Rhinebeck Foot Care to RECEIVE my protected health information (PHI) from:

Name:		**Name:**	
Address:		**Address:**	
Phone #		**Phone #**	

- I release the entities listed above their agents and employees from any liability in connection with the use or disclose of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the receipt and no longer protected by the Privacy Rule.
- I have a right to inspect the health information to be released and may refuse to sign this authorization.
- THE INFORMATION AUTHORIZED FOR THE USE OF DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILLIS, GONORRHEA OR THE HUMAN IMMUNNODEFICIENY VIRUS, ALSO KNOWN AS IMMUNE DEFICIENCY SYNDROME (AIDS).

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release RHINEBECK FOOT CARE, affiliates, agents and employees from any liability in connection with the release of the information contained therein.

Patient Signature/Legal Representative Date

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I authorize Rhinebeck Foot Care to VERBALLY discuss the following medical and billing information about me (check all that apply):

☐	Scheduling/appointment information
☐	Medical information including my symptoms, diagnosis, medications and treatment plans
☐	Lab/test results
☐	Billing and payment information
☐	Other:

Rhinebeck Foot Care has my permission to discuss the above information with:

Name	Phone	Relationship

I hereby authorize Rhinebeck Foot Care for any provider having treated me or my dependent, to release to government agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Signed: _____ Date: _____