



FOOT HEALTH CENTER, L.L.C./PATIENT HEALTH HISTORY FORM

Name: _____ **Date:** _____

Gender: (Male) (Female)

Name of Primary Care Physician (Address and Phone # if known) _____

Pharmacy Name (Address and Phone #) _____

Age: _____ **Height:** _____ **Weight:** _____

Please list ALL medications you are taking (prescriptions and/or over the counter): _____

Do you have any Allergies?(Food/Drugs/Latex/Seasonal) _____
If yes, what is your reaction? _____

Chief Complaint/Concern: _____

Describe your pain (circle those that apply);
sharp/burning/shooting/achy/knifelike/twisting/pressure/toothache/deep/heavy/gnawing/throbbing/dull/pulsating

How long have you experienced pain for? _____

What makes pain worse? _____ **What makes pain better?** _____

What medicines have you taken for your pain? _____

How severe is your pain? _____
0(no pain) 1-2(tolerate without medication 3-4(tell someone about my pain, take aspirin or Motrin)
5-6(mild narcotic, ex. Tylenol #3), 7-8(go to the emergency room, take strong narcotic) 9-10(admission to the hospital for pain control)

Immunizations: Are they up to date? Yes/ No **Date of Last Tetanus Shot** _____

PAST MEDICAL HISTORY (please circle any that apply)
Hypertension/ High Cholesterol/ Asthma/Diabetes/ Arthritis/ Back Injury/ Cancer/ Peptic Ulcer/ Gastric Reflux/ Heart Disease/Angina/ Arrhythmia/ Mitral Valve Prolapse/ Seizures/HIV/ Hepatitis/ Gout/ Sickle Cell Disease/ Kidney Disease/ Other _____

Past Surgeries _____

Social History: Type of job _____

Do you smoke? Yes/ no **Have you ever smoked?** Yes/ No **If yes, how many packs/ day?** **For how many years?** _____

Do you consume alcohol? If yes, how much/often? _____

Who do you live with? _____

Hobbies/Sports: _____

Family History: List any diseases of parents, siblings, children , or grandparents:

For Women Only: Are you pregnant or nursing? _____

Review of Systems: Please circle any that apply:

CONSTITUTIONAL: weight change, weakness, fatigue, fever

EYES: glasses, pain, tearing, double vision

EARS, NOSE, MOUTH AND THROAT: tinnitus, dizziness, pain, sinus, colds, sore throat

CARDIOVASCULAR: high blood pressure, rheumatic fever, murmurs, shortness of breath, chest pain, palpitations

RESPIRATORY: cough, sputum, coughing up blood, wheezing asthma, bronchitis, chest pain, breathing problems

GASTROINTESTINAL: difficulty swallowing, heartburn, vomiting, diarrhea, indigestion, pain, blood, stool changes

GENITOURINARY: pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence

SKIN: rash, lumps, itching, dryness, color change, hair changes, nail changes

NEUROLOGICAL: fainting, blackouts, seizures, paralysis, memory loss

PSYCHOLOGICAL: nervousness, tension, mood changes, depression, anxiety

ENDOCRINE: heat or cold intolerance, sweating, thirst, hunger, change in urination

HEMATOLOGY/LYMPHATICS: bruising, bleeding, transfusion reactions

ALLERGIES/ IMMUNOLOGICAL: drug, product or other allergies

REPRODUCTIVE: sexual dysfunction, pregnancy

MUSCLE/SKELETAL: back, joint, or muscle pain

Comments:

_____Date

Dr. Michael V. Verdi, D.P.M.
Dr. Jordan S. Steinberg, D.P.M.

FOOT HEALTH CENTER, LLC/ PATIENT DEMOGRAPHICS FORM

Patient Name:

(Last) _____ (First) _____ (M) _____

Street Address _____ Apt # if applicable _____

City: _____ State _____ Zip _____

Home Telephone _____ Cell Number _____ Work number _____

Email: _____ SS# _____ DATE OF BIRTH _____

Name of Parent(s)(if child is patient) _____ Name of Spouse(if married) _____

Emergency Contact (Name & Telephone) _____

Referral source _____

Primary Language _____ Race _____ Ethnicity _____

Contact Preferences () Phone () Mail () Email

Our current privacy practices do allow us to call you with a courtesy reminder call regarding upcoming appointment(s).

Please leave my courtesy reminder calls for upcoming appointment on the following number _____

Ok To leave message with () Patient Only () Patient and/or Family member () Anyone Answering

If you do not wish to have courtesy reminder calls for upcoming appointments, please be aware that there is a cancellation fee of \$25.00 if not cancelled within 24 hours, please initial _____

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to leave detailed messages (i.e. lab results, orthotics, surgery times, etc.) when possible. In order to protect your privacy we need your written permission to leave such detailed telephone messages on you answering machine or voice mail system.

I, _____ (signature), give Foot Health Center, LLC and their staff my permission to leave telephone messages regarding my medical care at the following number(s):

() Home phone/answering machine () Cell number/voicemail () Spouse/ anyone answering phone () Other

Please present primary and secondary insurance card(s) so we may make a copy. If you do not have your card you will be responsible for services rendered at that time, due to the overwhelming addresses for each insurance company and the necessity of having your ID#. As well as if a referral is needed you need to supply at time of visit. Please take note this office will only submit to two insurances. If this is workers compensation, auto claim, or claims going to your lawyer, please supply that information on date of service... But please take note you will ultimately be responsible for bill.

Do you have medical insurance: (yes) (no)

If Billing address is different than patient address _____

What is your relationship to Policy Holder? (Self) (Spouse) (Child)

Insurance Information:

Primary Insurance

Company Name: _____ Insurance# _____ Group# _____

Address _____

Copay (amount) _____ Deductible (amount and if met) _____ Coinsurance _____

Referral (if needed, please supply number) _____

Policy Holder Information (if not self)

Name _____ Address (if different) _____

Policy holder date of birth _____ Policy holder SS# _____

Secondary Insurance

Company Name: _____ Insurance# _____ Group # _____

Address _____

Copay (amount) _____ Deductible (amount and if met) _____ Coinsurance _____

Referral (if needed, please supply number) _____

Policy Holder Information (if not self)

Name _____ Address (if different) _____

Policy holder date of birth _____ Policy holder SS# _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM(S) AND HEREBY ASSIGN FOOT HEALTH CENTER, LLC (DR. MICHAEL VERDI & DR. JORDAN STEINBERG) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO SELF OR DEPENDENTS.

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL OF THE CHARGES FOR ALL OF THE SERVICES AND/ OR PRODUCTS RENDERED TO ME OR ANY MEMBER OF MY FAMILY.

ALTHOUGH I HAVE REQUESTED THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT IF A BILL IS NOT PAID BY MY INSURANCE WITHIN A TIMELY MANNER, I AGREE TO MAKE ARRANGEMENTS FOR PROMPT PAYMENT TO FOOT HEALTH CENTER, LLC.

I AGREE TO HAVE A VALID REFERRAL (IT IS POLCYHOLDER'S RESPONSIBILITY TO KNOW IF INSURANCE REQUIRES REFERRAL) FOR VISIT AND ANYTIME INSURANCE CHANGES.

PLEASE NOTE: IF YOU HAVE NO INSURANCE YOU WILL BE RESPONSIBLE FOR PAYEMENT AT TIME OF SERVICES.

Patients Signature: _____

Guardian or other responsible party Signature: _____

Today's Date: _____

Insurance Information

Primary Insurance Co. Information:

Company Name: _____

Address: _____

Insurance # _____

Group # _____

Do you have a Co-pay?
(YES) Amt\$ _____ or (NO)**Secondary Insurance Co. Information:**

Company Name: _____

Address: _____

Insurance # _____

Group # _____

Do you have a Co-Pay?
(YES) Amt\$ _____ or (NO)**Policy Holder Information (if not self)**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Date of Birth _____

Policy Holder SS# _____

Policy Holder Information (if not self)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Date of Birth _____

Policy Holder SS# _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO DR. VERDI OR DR GOLDBERG ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO SELF OR DEPENDENTS.

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL OF THE CHARGES FOR ALL OF THE SERVICES RENDERED TO ME OR ANY MEMBER OF MY FAMILY.

ALTHOUGH I HAVE REQUESTED THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT IF A BILL IS NOT PAID BY MY INSURANCE WITHIN A TIMELY MANNER, I AGREE TO MAKE ARRANGEMENTS FOR PROMPT PAYMENT TO DR. VERDI OR DR. GOLDBERG.

I AGREE TO HAVE A VALID REFERRAL (IT IS POLICYHOLDER'S RESPONSIBILITY TO KNOW IF INSURANCE REQUIRES REFERRAL) FOR VISIT AND ANYTIME INSURANCE CHANGES.

PLEASE NOTE: IF YOU HAVE NO INSURANCE YOU WILL BE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICES.

Patient's Signature: _____

Guardian's Signature:
(or other responsible party) _____

Today's Date: _____

Your Health Information Rights

Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit your request in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Foot Health Center, LLC in writing. The cost for copying releases of PHI is \$1.00 per page.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Foot Health Center, LLC will provide the first accounting to you in any 12-month period without charge, upon your written request. The cost for subsequent requests for an accounting within the 12-month period will be \$10.00.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about

medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the practice and submit your request in writing to the practice's privacy officer indicated below.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (973) 731-1266 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services by calling 1-800-368-1019, or by contacting the Office of Civil Rights regional office. All complaints must be also submitted in writing within 180 days of when you knew that the act or omission complained of occurred. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: **Robin Verdi, RN**
Telephone Number: (973) 731-1266

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Foot Health Center

1500 Pleasant Valley Way
West Orange, NJ 07052
Phone: (973) 731-1266
Fax: (973) 731-1712

Health Insurance
Portability and
Accountability Act of 1996

Notice of Privacy Practices

Effective April 14, 2003

Last Modified: January 15, 2008

FOOT HEALTH CENTER, I C.
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ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided 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.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature