



Practice of Podiatric Medicine and Surgery
 91 Montgomery Street, Rhinebeck, NY 12572
 Office: (845) 876-8637 Fax: (845) 876-0218
 www.rhinebeckfootcare.com

PATIENT INFORMATION					
Name (Last, First, M.I.):			<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Age:
Soc. Sec. #:					
Street Address:			City:	ST:	Zip:
Home Phone:		Cell Phone:		Work Phone:	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Other Pacific Island		Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Island	
Communication Preference: <input type="checkbox"/> Email <input type="checkbox"/> Postal <input type="checkbox"/> Telephone			Referred by: <input type="checkbox"/> Patient <input type="checkbox"/> Doctor <input type="checkbox"/> Insurance		Ref. Name:
Email address:					
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
CONCERNING INSURANCE					
<p>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.</p> <p>I have read the above and fully understand my financial responsibilities for all services and materials received in this office.</p>					
Signature:		Printed Name:		Date:	



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Please describe your foot problem:			
Have you had any previous foot care or surgery:		<input type="checkbox"/> No <input type="checkbox"/> 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			
<input type="checkbox"/> Amputation	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hemophilia (bleeder)	<input type="checkbox"/> Phlebitis (Blood Clots)	
<input type="checkbox"/> Anxiety Disorders	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Polio	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV	<input type="checkbox"/> Respiratory Condition	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Cardiac Disease	<input type="checkbox"/> Keloid Former	<input type="checkbox"/> Sexually Transmitted Disease	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Circulation Problems	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Slow to heal	
<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Varicose Veins	
<input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> Mitral Valve Prolapse		
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Muscular Disease		
<input type="checkbox"/> Gout	<input type="checkbox"/> Nervous System Disorder		
<input type="checkbox"/> Other:			
Female Patients, are you Pregnant:		<input type="checkbox"/> No <input type="checkbox"/> Yes	If "Yes" Due Date: / /
AUTHORIZING AND RELEASE			
<ul style="list-style-type: none"> 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:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If "Yes" Amount Per Week:		Caffeine:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If "Yes" Cups per day:			
Tobacco:	Never a Smoker: <input type="checkbox"/>	Former Smoker: <input type="checkbox"/>	Years quit:						
	<input type="checkbox"/> Current every day smoker	Packs per day:		How many years:					
	<input type="checkbox"/> 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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I authorize Rhinebeck Foot Care to VERBALLY discuss the following medical and billing information about me (check all that apply):

<input type="checkbox"/>	Scheduling/appointment information
<input type="checkbox"/>	Medical information including my symptoms, diagnosis, medications and treatment plans
<input type="checkbox"/>	Lab/test results
<input type="checkbox"/>	Billing and payment information
<input type="checkbox"/>	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: _____