

**PATIENT BACKGROUND**

**PATIENT'S NAME** \_\_\_\_\_  
LAST FIRST MIDDLE SPOUSE/PARENT

**ADDRESS** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **CELL:** \_\_\_\_\_

**AGE** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ **SEX** \_\_\_\_\_ **MARITAL STATUS** \_\_\_\_\_ **SOC. SEC. NO.** \_\_\_\_\_  
Last 4 digits

Guardian's name if patient is a minor \_\_\_\_\_

Guardian's address if different from above \_\_\_\_\_

**PHARMACY NAME, LOCATION AND PHONE NO.** \_\_\_\_\_

**OCCUPATION** \_\_\_\_\_ **EMPLOYER** \_\_\_\_\_ **BUSINESS ADDRESS** \_\_\_\_\_ **PHONE NO.** \_\_\_\_\_

**OCCUPATION OF SPOUSE OR PARENT** \_\_\_\_\_ **EMPLOYER** \_\_\_\_\_ **BUSINESS ADDRESS** \_\_\_\_\_ **PHONE NO.** \_\_\_\_\_

**PERSON RESPONSIBLE FOR BILL** \_\_\_\_\_  
NAME ADDRESS PHONE NO.

**IN CASE OF EMERGENCY, CONTACT** \_\_\_\_\_ **PHONE NO.** \_\_\_\_\_

**HEALTH INSURANCE CARRIER(S), ID NO.** \_\_\_\_\_

Please tell us, as well as you can, the main problem, as well as other problems, that bring you to our office for help

Have you ever been to a podiatrist? \_\_\_\_\_ **HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_ **SHOE SIZE** \_\_\_\_\_

Please answer the following questions related to your general health so we may better know you and your medical background. The feet reflect systemic problems, and conversely, often the feet reflect bodily functions.

**I am allergic to (please check)**

- Aspirin                       Iodine                       Penicillin                       Other \_\_\_\_\_
- Codeine                       Latex                       Sulfa                      \_\_\_\_\_
- Demerol                       Novocain                       Tape                       Nothing that I am aware of

Are you in  good health       fair health       poor health

**Tobacco use:** Never \_\_\_\_\_ Current/packs a day \_\_\_\_\_ Quit Date \_\_\_\_\_

Physician's **NAME AND ADDRESS** \_\_\_\_\_

Are you under the care of a doctor? \_\_\_\_\_ If yes, please state problem \_\_\_\_\_

What medications are you now taking? \_\_\_\_\_

Do you, or have you ever had, any of the following?

- Anemia                       Diabetes                       Heart Trouble                       Rheumatism  Tumors
- Arthritis                       Epilepsy                       High Blood Pressure                       Scarlet Fever
- Asthma                       Glaucoma                       Kidney/Bladder Trouble                       Stomach Ulcers
- Bleeding Tendencies                       Gout                       Nervousness                       Stroke
- Cancer                       Heart Murmur                       Rheumatic Fever                       Tuberculosis

**SURGERIES:** \_\_\_\_\_



# Westside Podiatry Group, LLC

*fellows American College of Foot and Ankle Surgeons  
diplomates American Board of Podiatric Surgery*

## **OFFICE FINANCIAL POLICY**

Our financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their medical care.

1. Full payment is expected at the time of service unless other arrangements are made. There will be an additional charge of \$10.00 for copayments not made at the time of the visit.
2. A service charge of \$5.00 per month on the unpaid balance will be charged after 30 days.
3. If an appointment is broken and not canceled, a charge of \$48.00 will be applied to your account.
4. Returned checks are subject to a \$20.00 service charge and will terminate your privilege to pay by check in the future.
5. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agent or attorney for recovery, that the patient will be fully responsible for any costs, including, but not limited to attorney's fees.

## **RELEASE OF INFORMATION AND HIPAA SIGNATURE:**

I hereby authorize Westside Podiatry Group to release all information regarding services rendered to my insurance company/Medicare, keep my signature on file, and to accept third-party payments from my insurance company. However, I agree to take financial responsibility for co-payments, deductibles, and any amounts not covered by my insurance company.

I acknowledge that I have had the opportunity to read the Privacy Practice Act located in the reception area, and I understand the notice.

**Please sign below to indicate you have read the above Office Financial Policy section and the Release of Information and HIPAA section and understand them fully.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

GREECE OFFICE  
2236 RIDGE ROAD WEST  
ROCHESTER, N.Y. 14626  
(585) 225-2290  
FAX (585) 225-1367

GATES-CHILI OFFICE  
507 BEAHAN ROAD  
ROCHESTER, N.Y. 14624  
(585) 247-2170  
FAX (585) 247-3614

BRIGHTON OFFICE  
919 WESTFALL ROAD  
BUILDING C, SUITE 130  
ROCHESTER, N.Y. 14618  
(585) 506-9790  
FAX (585) 697-0116



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## PATIENT PRIVACY AUTHORIZATION

1. Please list any family members or other person(s), if any, whom we may inform about your general condition and your diagnosis:

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2. Please list the family members or significant others, if any, whom we may inform about your medical condition in an emergency (if different from above).

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3. May confidential messages (i.e. lab reports, X-ray results, appointments, etc) be left on your  home answering machine,  voicemail or  with family members? Please check all for which you grant consent.

4. May we call you at work?  Yes  No

5. If necessary, may we fax your protected health information to another doctor's office, insurance company, employer, pharmacy, school, attorney, town offices (handicap parking), nursing/resident home?  Yes  No. Please be advised that checking "No" may lead to significant delays in important communications regarding your health care.

6. Please list any other pertinent information you think this office should know regarding your privacy.

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7. I am aware that a cellular phone is not a secure phone line.

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Print Name

Signature

Date

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