New Patient History

Patient Name _____ **Date** _____

Referred by: _____

HISTORY

Chief Complaint _____

❑ Unable to obtain a comprehensive history due to patient's condition

History of Present Illness

Location _____ **Quality** _____

Severity _____ **Duration** _____

Timing _____ **Onset** _____

Aggravating Factors _____

_____

Medical History

Diabetes	No	Yes	Hepatitis/Liver Disease	No	Yes	**Medications**	
Hypertension	No	Yes	Arthritis/Gout	No	Yes		
Cancer/Tumors	No	Yes	Artificial joints	No	Yes		
Stroke	No	Yes	Back problems	No	Yes		
Neurological Disorders	No	Yes	Hereditary defects	No	Yes		
Convulsions	No	Yes	Glaucoma	No	Yes		
Heart trouble/ Murmur	No	Yes	Kidney/Bladder Disease	No	Yes		
Rheumatic Fever	No	Yes					
Asthma	No	Yes	**PastHosp/Surgeries/Injuries**				
Tuberculosis	No	Yes					
Anemia	No	Yes					
Acute Infections	No	Yes					
Stomach ulcers	No	Yes					

Social History

Marital status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Tobacco use	☐ Never	☐ Previously, but quit (date) _____		☐ Current packs/day _____	
Alcohol use	☐ Never	☐ Rarely	☐ Moderate	☐Daily	
Drug use	☐ Never	Type/frequency _____			

Occupation _____ ☐Sedentary ☐Standing

Sports/ Activity _____

Shoe Wear ☐Sneakers ☐Dress ☐Casual ☐Boots Size _____

Family Medical History

	AGE	Diseases	If deceased, cause
Father			
Mother			
Siblings			
Spouse			
Children			

PATIENT'S NAME _____
Last **First** **MI** **Spouse/Parent**

_____
ADDRESS **ZIP**

PHONE NO. _____ **CELL PHONE NO.** _____

AGE____ **DATE OF BIRTH**_____**SEX**____ **SOC. SEC. NO.** _____
Last 4 numbers

PHARMACY/LOCATION/PHONE_____

_____
EMPLOYER **ADDRESS** **PHONE NO.**

_____
SPOUSE EMPLOYER **ADDRESS** **PHONE NO.**

PERSON RESPONSIBLE FOR BILL_____
NAME

_____
ADDRESS **PHONE AND/OR CELL PHONE NO.**

EMERGENCY CONTACT AND PHONE NO._____

INSURANCE CO./ID NO. _____

Have you ever been to a podiatrist ___ **HEIGHT** _____ **WEIGHT**_____ **SHOE SIZE**_____

Have you had previous treatment? If so, explain _____

_____

ALLERGY/IMMUNOLOGY(history of reaction to the following):

Codeine	**Yes**	**No**	**Aspirin/other pain remedies**	**Yes**	**No**
Iodine/Shellfish	**Yes**	**No**	**Morphine/other narcotics**	**Yes**	**No**
Penicillin	**Yes**	**No**	**Novocain/other anesthetics**	**Yes**	**No**
Sulfa	**Yes**	**No**	**Tetanus antitoxin/other serums**	**Yes**	**No**

ALLERGY to other drugs or medications _____

FOOD ALLERGIES/REACTIONS_____

PHYSICIAN'S NAME/ADDRESS/PHONE NO. _____

_____

Are you currently under the care of a physician? YES _____ **NO**_____

If yes, please state reason or problem _____

Last Physical _____

Date you last saw physician _____

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:

   _____

   _____

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).

   _____

   _____

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.

   _____

   _____

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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