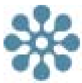


NEW YORK FOOT & ANKLE

DELIVERING ONLY PREMIUM PODIATRIC CARE

MEDICAL HISTORY

- □ AIDS/HIV
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Bleeding Disorders
- □ Cancer
- □ Chemical Dependency
- □ Chest Pain
- □ Circulatory Problems
- □ Diabetes
- □ Epilepsy
- □ Foot or Leg Cramps
- □ Fainting
- □ Eye Problems
- □ Gout
- □ Hepatitis
- □ High Blood Pressure
- □ Kidney Problems
- □ Liver Disease
- □ Psychiatric Care
- □ Phlebitis
- □ Low Blood Pressure
- □ Nervous
- □ Radiation Treatment
- □ Rheumatic Fever
- □ Shortness of Breath
- □ Sinus Problems
- □ Stroke
- □ Swelling (Ankles/Feet)
- □ Venereal Disease
- □ Tuberculosis
- □ Ulcers
- □ Varicose Veins

□ Other:____

Do you smoke? □Yes □No □Quit Years smoked:_________ Packs per day:______________

Past Surgical History ____

Please indicate which foot problems you now have or have had in the past:______________________

Hospitalizations: ____

Family Physician: ____ Last visit date:____/____/___

Physician Phone#: ____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins:

____

____

____

____

____

____

____

____

ALLERGIES

- □ None
- □ Adhesive Tape
- □ Aspirin
- □ Anticoagulant Therapy
- □ Codeine
- □ Demerol
- □ Sulfa
- □ Iodine
- □ Local Anesthesia
- □ Novocain
- □ Latex
- □ Penicillin
- □ Seafood
- □ Other________

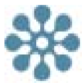
Pharmacy Name: ____________________

Pharmacy Phone:____________________

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures which may be appropriate for diagnosis and treatment of my feet.

Patient's Signature________________________________ Date______________________



NEW YORK FOOT & ANKLE

DELIVERING ONLY PREMIUM PODIATRIC CARE

PATIENT INFORMATION

Patient___________________________________

Street Address ________________________

Apt_______ City ________________________

Zip Code ________

Phone Numbers:

Home___________________________________

Work___________________________________

Mobile__________________________________

Social Security # ____________________

Birth Date___/___/___ Age______

Sex: □Male □Female

Spouse Name___________________________

Whom can we thank for referring you?

____

IN CASE OF EMERGENCY CONTACT:

Name______________________________

Relationship__________________________

Phone ______________________________

INSURANCE INFORMATION

Insurance Company ___________________

Who is responsible for this account? ______

Relationship to Patient__________________

Group # _____________________________

Is Patient covered by additional insurance?

□Yes □No

Secondary Insurance Co _______________

Subscriber Name _____________________

Social Security # _____-_____-_____

Birth Date ___-___-___

Relationship to Patient_________________

Employer ___________________________

Occupation __________________________

INSURANCE AUTHORIZATION

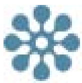
I request that payment of authorized Medicare or other Insurance benefits be made either to me or on my behalf to Dr. Shibu Kinatukara for any services furnished to me. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare carrier as the full charge, and the patient is responsible only for the deductible are based upon the charge determination of the Medicare carrier.

____

Beneficiary Signature

____

Date



NEW YORK FOOT & ANKLE
DELIVERING ONLY PREMIUM PODIATRIC CARE

PRIVACY PRACTICES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Shibu Kinatukara to use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare operations (TPO).

I have the right to review the notice of privacy practices prior to signing this consent. Dr. Shibu Kinatukara reserves the right to revise its notice of privacy practices at anytime. A revised notice of privacy practices maybe forwarding a written request to NY Foot & Ankle Surgery, Attn: Office Manager, 1640 Ocean Avenue, Brooklyn, NY 11230.

With this consent, Dr. Shibu Kinatukara may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent, Dr. Shibu Kinatukara may e-mail to me any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Shibu Kinatukara restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Shibu Kinatukara's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Dr. Shibu Kinatukara may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian Date

____
Patient Name

____
Print Name of Patient or Legal Guardian