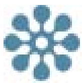


NEW YORK FOOT & ANKLE

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________

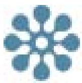
Pharmacy Name: ____________________

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