FINE FAMILY FOOT CARE

ROBERT M. FINE, D.P.M.

Board Certified, American Board of Podiatric Orthopedics and Primary Podiatric Medicine

9 Clark Street
Hudson Falls, New York 12839
Telephone: (518) 747-2372

Dear_____

Appointment Date_____

We would like to welcome you to our practice.

Please fill out the enclosed forms and return them to us prior to appointment.

Please remember to bring any reports or x-rays you may have.

Remember your insurance cards. Payment is due at the time of your visit.

OUR OFFICE DOES NOT ACCEPT CREDIT OR DEBIT CARDS

CASH OR CHECK ONLY!!!

If you no longer need this appointment or you have any questions, PLEASE call 518-747-2372.

THANK YOU FOR YOUR COOPERATION

NOTICE TO ALL MEDICARE PATIENTS

DR. ROBERT FINE **DOES NOT** PARTICIPATE WITH MEDICARE.

THIS MEANS IF MEDICARE IS YOUR PRIMARY INSURANCE,
PAYMENT WILL BE DUE IN FULL AT THE TIME OF YOUR VISIT.

IF YOUR VISIT IS COVERED UNDER THE MEDICARE GUIDELINES,
A CLAIM WILL BE SENT TO THEM

****Please note that Dr. Fine participates in many Medicare Advantage Plans. For Example: Senior Blue, MVP Gold, United Healthcare Medicare Solutions.**
Your co-pay would be due at the visit.

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Hudson Falls, NY 12839

518-747-2372

PATIENT REGISTRATION

Last Name_____ **First Name**_____ **MI**_____

Address _____

City _____ **State**_____ **Zip Code**_____

Home Phone(_____)_____ **Cell:** (_____)_____

Work:(_____)_____

Birth Date _____/_____/_____ **Age**_____

Please note we are gathering email addresses for our patient portal, your email address will Only be used to send you secure messages IF you sign up for access to our patient portal.

Email Address_____ **Not interested at this time**_____

Whom may we thank for referring you?_____

Meaningful use of electronic medical records includes the collection of the following Demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: (select one)Male/Female

Marital Status: (select one) Single/Married/Divorced/Widow/Other:_____

Race: (Select one)

Caucasian/African American/Asian/Native Alaskan/Native Hawaiian/Pacific Islander/ Declined

Ethnicity:(select one):English/French/Spanish/Other_____

Primary Language: (select one):English/French/Spanish/Other_____

FINE FAMILY FOOT CARE

HIPPA CONSENT OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____ Date: _____

I do ____, I do not ____ give permission to leave relevant medical information on my answering machine or voicemail.

I wish to be called at home ____ or other ____ with my lab, radiological or other test results. The best telephone number(s) to reach me are:

Home _____ and/or Other: _____

This authorization shall be in force and effect until **1 year from date signed**, at which time this authorization to use or disclose the described health information expires.

I understand that it is my responsibility to notify the practice if my telephone number changes. I understand that health information left by my physician on my answering machine or voice mail may be overheard by family members or other individuals. I also understand that while unlikely, it is possible that my health information may be accidentally left on an answering machine that does not belong to me.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____

Patient's Signature Date

OR

_____ _____

Personal Representative's Signature Date

CONSENT: I consent to the use or disclosure of my protected health information by Fine Family Foot Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the healthcare operations of Fine Family Foot Care. I understand that diagnosis or treatment of me by Fine Family Foot Care may be conditioned upon my consent as evidenced by my signature on this document.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I understand that Fine Family Foot Care's Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of Fine Family Foot Care. By signing this document I acknowledge that a copy of Fine Family Foot Care's Notice of Privacy practices has been provided to me.

Cancellation Policy: If you are not able to make your appointment, please notify our office at least one day prior to the appointment. We reserve the right to charge a fee for appointments cancelled with less than 24 hours notice.

Patient's Signature: _____ Date: _____

INSURANCE INFORMATION

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU
WE WILL MAKE A COPY OF YOUR CARD(S)

INSURANCE ASSIGNMENT AND RELEASE

MEDICARE AUTHORIZATION

I understand that Dr. Robert Fine is NOT a Medicare participating provider and that I am financially responsible for all charges at the time services are rendered. A Medicare claim will be submitted for your visit and reimbursement of authorized Medicare benefits will be sent to you.**

To the extent permitted by law, I authorize any holder of medical or other information about me be released to the Centers for Medicare Services and their agents needed to determine these benefits or benefits for related services.

I authorize the use of my signature on Medicare Insurance submissions.

_____ _____

Signature of Beneficiary, Guardian, or Personal Representative **Date**

*****************OTHER INSURANCE AUTHORIZATION*****************

I certify that I have insurance coverage with: _____

and assign directly to Dr. Robert Fine all insurance benefits, if any, from Insurance Plans he participates with, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Name of Insured: _____ **Relationship:** _____
Date of Birth of Insured: _____

I authorize the use of my signature on all insurance submissions.

_____ _____

Signature of Beneficiary, Guardian, or Personal Representative **Date**

Fine Family Foot Care

9 Clark Street

Hudson Falls, New York 12839

Phone (518) 747-2372

Fax (518) 747-2543

Employer _____

Employer's Address _____

Guarantor Information

Person Responsible for the bill (if other than the patient) OR Parent if Patient is a minor

Name of Parent/Guardian _____

Address (if different from above) _____

Home Phone Number (if different from above) _____

Work Number _____ Cell Number _____

Emergency Contact

Name: _____ Relationship _____

Phone Number: _____ Cell Number: _____

Patient Name_____ Date_____

Patient Date of Birth_____

MEDICAL INFORMATION AND HISTORY

Describe your foot problem_____
_____

How long have you had this problem? Days ____Weeks ____Months _____Years____

How would you rate your pain on a scale from 0 to 10? Please Circle one
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

What makes your problem/pain feel worse? Walking____Running____Standing____
Any physical Activity ____Resting ____Dress shoes ___High heels ____Flat shoes____
Closed toe shoe ____Other_____

What makes your problem or pain feel better?_____
_____

What treatments have you had for this problem/pain?_____
_____

Have you had X-Rays done for this problem/pain? Yes ____No____
PLEASE BRING X-RAYS WITH YOU ON YOUR APPOINTMENT

Was the problem/pain related to an injury? Yes _____No____
If yes? Was it a work-related injury? Yes ____No____

****

MEDICAL CONTACTS:

Who is your Primary Care Physician?_____
Address:_____
Phone #_____

Name of Specialists who are treating you (Endrocrinologist, Nephrologist, Cardiologist)

_____

May we contact your Primary Care/Specialist Physician for any additional medical history?
_____Yes _____No

What Retail Pharmacy do you use?_____
Location:_____ Phone:_____

CURRENT MEDICATIONS:

Name of Medication Dose How often do you take?

_____

_____

_____

_____

_____

_____

DRUG ALLERGIES: _____ No Allergies

Antibiotics: Sulfa _____Penicillin _____Other_____
Pain Medication: _____Latex _____Iodine____ Tape____

HEIGHT_____WEIGHT_____SHOE SIZE_____

History of Falling: ____ No Falls within the last 2 years
____ Less than 2 falls within the last year
____Greater than 2 falls within the last 2 years

Vaccinations:

Pneumonia	___Yes	___No	___Unknown
Influenza	___Yes	___No	___Unknown
Shingles	___Yes	___No	___Unknown
Tuberculosis skin test	___Yes	___No	___Unknown
Covid	___Yes	___No	___Unknown

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please review the following list and place a check mark next to any of he problems that have significantly affected you recently or in the past.

Constitutional
__Weight Gain
__Weight Loss
__Fatigue
__Fever/Chills
__Loss of Appetite

Cardiovascular
__Pain in Chest
___Irregular Heart Beat
___Murmur

Skin
__Rash
__Sun Sensitivity
__Hair Loss
__Color changes fingers/toes from
__Pitting of nails

Respiratory
___Shortness of Breath
___Frequent Cough
___Coughing Blood
___Exposure to TB

Neurological
__Headaches
__Numbness
__Tingling
__Muscle Weakness
__Seizures

Gastrointestinal
___Nausea
___Vomiting
___Diarrhea
___Constipation
___Loss of bowel control
___Bloddy Stool
___Persistent Heartburn

Endocrine
__Cold Intolerance
__Heat Intolerance
__Excessive Thirst
__Excessive Urination

Hematology
__Easy Bruising
__Easy Bleeding
__Night Sweats
__Enlarged Lymph Nodes

Musculoskeletal
__Morning Stiffness
__Joint Pain
__Neck Pain
__Back Pain

MEDICAL HISTORY:

Please list all past surgeries& hospitalizations with dates if known

_____

_____

_____

_____

Are you a diabetic? Yes _____No ____ Type 1____Type 2____
Number of years?_____

Do you have any of the following? Please check if applies to you?

___Heart condition/disease
___Circulation
___Arthritis
___Kidney disease
___Lung disorder
___Cancer
___Asthma
___Stomach condition
___Liver
___ Chronic Urinary Tract Infections
___Neurological disorder
___Hormone
___ Anemia
___ Bladder
___High Blood Pressure
___ Skin
___Gout
___Tuberculosis
___Rheumatic Fever
___Recent Weight gain/Weight loss
___ Poor healing
___ Intestines

Do you have any serious illnesses not listed above?_____
_____

Do you have any artificial limbs/and or joints? Yes____No___ Where?_____

Do you have any of the following? Heart Valve_____Pacemaker_____Defibrillator_____

SOCIAL HISTORY: Occupation: _____

Tobacco Use:
Never Smoked ____
Currently smoke every day ____ # of cigarettes/day ____
Currently smoke some days ____
I have quit ____ Age when stopped _____

Alcohol Use
Do you drink alcohol? Yes ____No____
How many per: Day ____Week _____Month____

Do you exercise? Daily____1-3 times a week ____Weekly ____Occasional ____Never____
What type of exercise?_____

FAMILY HISTORY:

Sometimes it is important to know the medical problems of your family members because some illnesses run in the family.

Do you have a family histoy of any of the following? Please indicate whether it it:
Mother (M) Father (F) Both (B)

Heart Disease ____Stroke ____Cancer ____Thyroid Disorder _____Diabetes_____

Rheumatoid Arthritis ____High Blood Pressure ____Other_____

ADVANCE CARE PLAN

For patients 65 old or older, do you have an advance care plan or a surrogate decision maker ie: durable Power of Attorney or healthcare proxy, DNR or living will.

Yes: _____ No: _____

TO THE BEST OF MY KNOWLEDGE I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR OR MEDICAL OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME:_____

SIGNATURE:_____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT:_____

SIGNATURE OF DOCTOR:_____

DATE:_____