NAME:____**DOB**: ____________________

ADDRESS: ____

HOME #:_____________________________**CELL #**:________________________________

SEX: (CIRCLE) *MALE FEMALE* **RACE**: __________________ **ETHNICITY:** __________________

MARITAL STATUS: (CIRCLE) SINGLE DIVORCED MARRIED WIDOWED SEPARATED

EMERGENCY CONTACT:______________________________**PHONE #**: _________________

EMPLOYER/ OCCUPATION: ____

PRIMARY INSURANCE: ______________________ **ARE YOU THE INSURED**: (CIRCLE) *YES NO*

SUBSCRIBER NAME AND ID#: __________________________**RELATIONSHIP**:_____________

SECONDARY INSURANCE: _________________**ARE YOU THE INSURED**: (CIRCLE) *YES NO*

SUBSCRIBER NAME AND ID#: __________________________**RELATIONSHIP:**_____________

IS THIS THE RESULT OF AN ACCIDENT? *(Circle) YES NO* **DATE OF INJURY**: __________

IF SO, *(circle) WORKERS COMP or NO FAULT INSURANCE*

PRIMARY CARE PHYSICIAN:___________________________**DATE LAST SEEN**: ___________

ENDOCRINOLOGIST:_________________________________**DATE LAST SEEN**: ___________

PHARMACY:_________________________**ADDRESS**: __________________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

WHAT IS THE REASON FOR YOUR VISIT? ____

____

HOW LONG HAS THIS BEEN BOTHERING YOU? ______________________________________

Please Read and Sign below:

The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information whether demographic or medical listed. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: ____ **Date**: ____________________

FINANCIAL POLICY

Thank you for trusting your medical care to Albany Podiatry. When you schedule an appointment with Albany Podiatry we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment kindly give at least 24 hour notice. This gives us sufficient time to schedule other patients who may be waiting for an appointment.

Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 24 hour notice will be considered a No Show and charged a $25.00 fee.

If a third No show/cancellation/reschedule without 24 hour notice should occur the patient will not be given any future appointments. We will give a transfer of care.

Copays are due at time of service to avoid a $10 processing fee.

Any balances not collected after 60 days will incur a $10 late fee.

You may contact Albany Podiatry 24 hours a day, 7 days a week at the number above. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left are acceptable.

- Assignment of benefits and Release of information: I authorize payment of medical benefits to Albany Podiatry. I authorize the release of any medical information necessary to process any claims to my insurance.
- I give Albany Podiatry consent to retrieve and use my medication history from SureScripts.

NAME: ____ **DOB:** ___________________________

MEDICAL HISTORY: ***check all that apply***

___ ALCOHOLISM	___ SLEEP APNEA	___ KIDNEY DISEASE	___ HYPERTENSION
___ BLOOD DISORDERS	___ GOUT	___ BLOOD CLOT	___ SKIN DISORDERS
___CIRCULATION PROBLEMS	___ ALLERGIES	___ HIGH CHOLESTEROL	___ STROKE
___ BREATHING ISSUES	___ HEART DISEASE	___ HIV	___ DIABETES:
___ LIVER	___ ASTHMA	___ CVA	TYPE 1 or TYPE 2
___THYROID DISEASE	___ ARTHRITIS	___ CANCER	___ HEPATITIS
Specify: ____________	*Specify:* __________	*Specify:* ___________	*Specify:* ___________

CURRENT MEDICATIONS: ____

____

ALLERGIES: ____

LAST FLU SHOT DATE: __________ **PNEUMOCOCCAL VACCINATION DATE** if over 65: ________

SURGICAL HISTORY: ____

ARE YOU PREGNANT? *(circle)* yes no **ARE YOU NURSING?** *(circle)* yes no

FAMILY HISTORY: ***check all that apply & indicate family member***

___ ALZEIMER'S: *Family member:* ___________	___ EMPHYSEMA: *Family member:* ___________	___ CATARACTS: *Family member:* ___________
___ DEPRESSION: *Family member:* ___________	___ BLOOD CLOT: *Family member:* ___________	___ NEUROLOGICAL: *Family member:* ___________
___ ARTHRITIS: *Family member:* ___________	___ HEART DISEASE: *Family member:* ___________	___ CIRCULATION PROBLEMS: *Family member:* ___________
___ DIABETES: *Family member:* ___________	___ CANCER: *Family member:* ___________	___ STROKE: *Family member:* ___________
___ BLEEDING DISORDERS: *Family member:* ___________	___ HIGH BLOOD PRESSURE: *Family member:* ___________	___ OTHER: ______________ *Family member:* ___________

SOCIAL HISTORY:

DO YOU SMOKE? (*circle*) current former no IF CURRENT, HOW MANY PACKS PER DAY? ___________

DO YOU DRINK ALCOHOL? *(check)* ____ yes, 5-7 days a week ____ yes, occasionally ____ no, rarely

SUBSTANCE ABUSE: *(circle)* yes no (current or past) *specify*: ______________________________

DO YOU EXERCISE REGULARLY? *(circle)* yes no *specify:* ________________________________

REVIEW OF SYSTEMS: ***check all that apply***

CV:

___ anticoagulant therapy
___ atrial fibrillation
___ blood clots
___ chest pain/ pressure
___ cold extremities (hands/feet)
___ heart disease
___ dizziness
___ hypertension
___ irregular heart beat
___ pacemaker
___ palpitations
___ pain in calves when walking
___ PVD
___ varicose veins
___ other: _____________
___ none

RESPIRATORY:

___ asthma
___ breathing difficulty
___ chest pain
___ COPD
___ cough
___ emphysema
___ oxygen use
___ sleep apnea
___ shortness of breath
___ respiratory disease
___ snoring
___ wheezing
___ other: ______________
___ none

GI:

___ abdominal pain
___ constipation
___ diarrhea
___ gallstones
___ heartburn
___ hernia
___ IBS
___ reflux
___ stomach ulcers
___ stool – blood
___ swallowing – difficulty/ pain
___ none

GU:

___ difficulty urinating
___ frequency
(cicle) <1hr >1hr
___ hesitancy
___ kidney stones
___ kidney disease
___ urgency
___ other: ______________
___ none

MUSCULO:

___ arthritis
___ fibromyalgia
___ instability
___ muscle aches
___ osteoarthritis
___ pain in back
___ pain in joints
___ pain in muscles
___ pain in neck
___ stiffness in joints
___ swelling of joints
___ weakness of joints
___ weakness of muscles
___ other: ______________
___ none

SKIN:

___ calluses
___ cellulitis
___ dryness
___ itchy skin
___ psoriasis
___ rash
___ skin cancer
___ sweating excessive
___ warts
___ nail symptoms
___ nail brittleness/ peeling
___ nail cracking
___ nail ingrown
___ other: _____________
___ none

NEURO:

___ dizziness
___ headaches
___ imbalance
___ neuropathy
___ numbness/ tingling in feet
___ paralysis
___ Parkinson's disease
___ seizures
___ stroke
___ tremor
___ none

HEMA/LYMPH:

___ anemia
___ anticoagulant use- long term
___ bleeding/ clotting disorder
___ bleeding/ bruising tendency
___ blood disease
___ vitamin B12 deficiency
___ vitamin D deficiency
___ other: _____________
___ none

SHOE SIZE: _______ **HEIGHT:** __________ **WEIGHT:** __________ **BLOOD PRESSURE:** _______