NEW PATIENT INTAKE FORM

PATIENT DEMOGRAPHICS

NAME		PREFERRED NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SEX ❑ FEMALE ❑ MALE	HOME PHONE	CELL PHONE	E-MAIL ADDRESS	
PERMANENT STREET ADDRESS		CITY	STATE	ZIP CODE

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	PCP FAX NUMBER	PCP ADDRESS
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

OCCUPATION	EMPLOYER		
EMPLOYER ADDRESS		EMPLOYER PHONE	

EMERGENCY CONTACT

FULL NAME CONTACT #1		ADDRESS		
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑ YES ❑ NO

FULL NAME CONTACT #2		ADDRESS		
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑ YES ❑ NO

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS				
POLICY NUMBER	GROUP/PLAN NUMBER			

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name

Name:		DOB:
Height:	Weight:	Age:

Chief Compliant

What is the reason for your visit?
(please list date of injury) _____

_____

_____

Pain level (no pain 0 – 10 highest):

When did this condition start?

Does anything make it better?

Does anything make it worse?

Have you tried any of the following?

Type
Anti-Inflammatory Medications:
Cold Application:
Injections:
Physical Therapy:
Other:

Medications

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Allergies

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Open Wounds/Ulcers	Yes	
Arrhythmia (Irregular heartbeat)	Yes		Osteoarthritis	Yes	
Asthma	Yes		Osteoporosis	Yes	
Bleeding Problems	Yes		Peripheral Vascular Disease	Yes	
Blood Clots (DVT)	Yes		Pneumonia	Yes	
Cancer	Yes		Psychiatric Illness (Depression)	Yes	
Diabetes	Yes		Pulmonary Embolus	Yes	
Heart Attack	Yes		Reflex Sympathetic Dystrophy	Yes	
Heart Disease	Yes		Reflux	Yes	
High Blood Pressure	Yes		Rheumatoid Arthritis	Yes	
High Cholesterol	Yes		Seizures	Yes	
Infection	Yes		Stroke	Yes	
Kidney Disorders	Yes		Ulcers	Yes	
Lung Disease	Yes		Other:	Yes	

For Females Only: Do you think you may be pregnant at this time? Yes No

Surgical and Hospitalization History

Previous Operation/Hospitalization	Year (approx.)	Any Complications?
1.		
2.		
3.		
4.		
5.		

Social History

Are you a tobacco user?
Do you consume alcohol?

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name

NOTICE OF PRIVACY PRACTICES

Privacy Officer: Paul Drucker, DPM
Jordan Drucker, DPM
Jarret Drucker, DPM
Martin McGrath, DPM

Effective Date: 4/14/03

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. It also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of the notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By the law, consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy.

Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent. Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

We may contact you to provide appointment reminders for treatment or medical care, and also to recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.

The law requires that you acknowledge receipt of this notice; this has been included on the signature release on the bottom of this form.

You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you. You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete or inaccurate.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

I acknowledge that I have read and understand the above Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Patient Name: _____

Notice of Non-Participation

I hereby acknowledge receipt of notice that my healthcare practitioner at Dr. Jarret Drucker Podiatry, PC (the"Practice") does not participate in my health care plan. Further, I hereby acknowledge that services rendered by a non-participating provider may result in costs not covered by my health care plan. I hereby acknowledge that I may request the amount or estimated amount the Practice will bill me for health care services.

Notice of Health Plan Participation

The Practice and Dr. Jarret Drucker participate with the following Health Plans: Medicare
Services rendered by a non-participating provider may result in costs not covered by your health care plan.

Health Plan, Hospital, and Other Provider Disclosure Acknowledgment

I hereby acknowledge receipt of notice by the Practice of the health plans the Practice and each Practice healthcare practitioner is a participating provider with, as well as notice of those hospitals with which the Practice, and in particular, my healthcare practitioner, is affiliated (if applicable). I hereby acknowledge that services rendered by a non-participating provider may result in costs not covered by my health care plan. I hereby acknowledge that I may request the amount or estimated amount the Practice will bill me for health care services. I am aware that the Practice and its healthcare practitioners reserve the right to change its/their affiliations (with third party payors, hospitals or other providers) at any time. I am also aware that I may request an updated list of health plans the Practice and each Practice healthcare practitioner is a participating

Surprise Bill Independent Dispute Resolution

A non-participating referred health care provider may submit a dispute regarding a surprise bill to the superintendent for review by an independent dispute resolution entity by:
1. Accessing Department of Financial Services Website for Application
2. Providing the following information:
a. the name and contact information of the physician or non-participating referred health care provider;
b. the name and contact information of the health care plan;
c. the fee charged by the physician or non-participating referred health care provider for the service that is the subject of the dispute, and provide a copy of the bill;
d. the fee paid to the physician or non-participating referred health care provider for the service that is the subject of the dispute;
e. at least three fees paid to the physician or, if the dispute involves a health care provider to the non-participating referred health care provider, in the last 12 months for the same services rendered by the physician or non-participating referred health care provider to other patients in health care plans in which the physician or nonparticipating referred health care provider is not participating, if available;
f. the physician's or non-participating referred health care provider's usual charge for comparable services rendered to other patients in health care plans in which the physician or non-participating referred health care provider is not participating;
g. the physician's or non-participating referred health care provider's level of training, education and experience;
h. an explanation of the circumstances and complexity of the particular case, including time and place of the service;
i. individual patient characteristics;
j. the usual and customary cost for the service, if available and applicable;
k. any other information the physician or non-participating referred health care provider deems relevant;
l. an attestation affirming that the information provided by the physician or non-participating referred health care provider is true and accurate; and
m. any information requested by the IDRE.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient Name