

DRS. NUSSBAUM, LUNDBERG, ALTMAN & PICKETT

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Hudson, New York 12534
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WELCOME TO OUR OFFICE

Please Print Clearly

Date _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Phone (Include Area Code) Home _____ Cell _____

Marital Status _____ Sex _____ Social Security Number _____

Birth Date ____ - ____ - _____ Age _____

Who referred you to our office _____

If it is necessary to contact you by phone:

When is the best time to call? _____ May we call you at work? _____

What is your e-mail address? _____

Patient' Employer _____

Address _____

Occupation _____ Is this visit work related? _____

Responsible Party (if other than patient)

Name _____ Relationship _____

Address _____ Phone _____

Health Insurance Information (Please give your ID cards to the Receptionist).

Please answer these questions about your health

Briefly describe your foot problem _____

Primary Doctor _____ Date of last visit _____

Doctor's Address (City and State) _____ Phone _____

What Pharmacy do you use _____

List Surgeries you have had _____

Have you had, or do you have problems with any of the following:

Yes No	Diabetes	Yes No	Thyroid or other endocrine disease
Yes No	Heart Problems	Yes No	Seizures or epilepsy
Yes No	Stroke or TIA	Yes No	Hepatitis, jaundice or liver disease
Yes No	Tingling or numbness in feet	Yes No	arthritis
Yes No	Gout	Yes No	Fractures
Yes No	Circulation problems	Yes No	Lung problems
Yes No	Shortness of breath	Yes No	Nose bleeds
Yes No	Kidney disease	Yes No	Urinary problems
Yes No	Fever or chills	Yes No	Unexplained weight loss
Yes No	Blurred vision	Yes No	Glaucoma
Yes No	Stomach ulcers	Yes No	Reflux or other digestive problems
Yes No	Abnormal blood pressure	Yes No	Psychiatric disorder

Yes No Do you drink liquor, wine or beer? If yes how often _____

Yes No Do you use "street drugs", e.g. marijuana, heroin, cocaine?

Race: _____ I prefer not to answer
(American, Indian, Asian, African American, Hispanic etc.)

Ethnicity: _____ I prefer not to answer

Preferred Language: _____ I prefer not to answer

Privacy Information Preferences

Were you offered a copy of the HIPAA Privacy Practice Notice? Yes No

Do you want to be exempt from public reporting? Yes No

Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No

Can we leave a voice message on answering machine? Yes No

Will you allow Internet based delivery reminders like email? Yes No

Who can we leave a message with Husband Wife Daughter Son

Other: _____

Smoking Status

Current Every Day Smoker

Current Some Day Smoker

Former Smoker

Never Smoker

I decline to answer

Vital Signs

Blood Pressure _____/_____

Height: _____

Weight: _____

I prefer not to answer

I do not know

Current Medications

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Allergy/Reaction

No known Allergies

Penicillin _____

Shellfish _____

Sulfa _____

Tape _____

Latex _____

Beta dine (iodine) _____

Aspirin _____

Tylenol _____

Ibuprofen _____

Codeine _____

Other _____

PATIENT NAME: _____

Mother Father Sister Brother

	Mother	Father	Sister	Brother
Alzheimer's				
Acute Arthritis				
Clotting & Bleeding disorders				
Blood Clot				
Cancer				
Bilateral Cataracts				
Other Circulatory disorders				
Chronic Depression				
Type I Diabetes Mellitus				
Type II Diabetes Mellitus				
Emphysema				
Heart Disease				
Essential Hypertension				
Neurological Disorder				
Ischemic Stroke				

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
(HIPPA)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Date

Name of Patient (Please Print)

Name of Parent or Authorized Representative (if applicable)

Signature

DRS. NUSSBAUM, LUNDBERG, ALTMAN & PICKETT

SIGNATURE OF FILE, ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Mark Schilansky, Dr. David Nussbaum and/or their associates for any services furnished me by that podiatrist. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient's Signature

Doctor's Signature

Date

OTHER INSURANCE AND/OR MEDICARE SUPPLEMENT

I request that payment of authorized insurance benefits be made either to me or on my behalf to Dr. Mark Schilansky, Dr. David Nussbaum and/or their associates for any services furnished me by that podiatrist. I authorized any holder of medical information to release any information needed to determine those benefits or benefits payable for the release any information needed to determine those benefits or benefits payable for related services. I also request that payment of authorized secondary (or MEDIGAP) benefits be made either to me or on my behalf to the Doctors above for any services provided. I authorize any holder of hospital or medical information needed to determine those benefits or benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I verify this is my signature and this authorization will remain in force until it is either cancelled or changed by me.

Patient's Signature

Date

DRS. NUSSBAUM, LUNDBERG, ALTMAN & PICKETT

PATIENT RESPONSIBILITY FOR UNCOVERED SERVICES

I, _____ hereby acknowledge that I will be responsible for any and all uncovered services including those services which may go towards satisfying my deductible. It is also understood that I will not be reimbursed by my insurance company or the physician for any and all payments made for uncovered services.

Date: _____

Patient Signature/ Responsible Party Signature:
