DRS. NUSSBAUM, LUNDBERG, ALTMAN & PICKETT

David N. Nussbaum, DPM, Lori A. Lundberg, DPM
Scott Altman, DPM & Scott Pickett, DPM

35 Five Mile Woods Road
Catskill, New York 12414
(518) 943-6800

67 Prospect Avenue, Suite 140
Hudson, New York 12534
(518) 822-1124

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 _____

Allergy/Reaction

____ No known Allergies
____ Penicillin _____
____ Shellfish _____
____ Sulfa _____
____ Tape _____
____ Latex _____
____ Beta dine (iodine) _____
____ Aspirin _____
____ Tylenol _____
____ Ibuprofen _____
____ Codeine_____
____ Other _____
_____
_____

PATIENT NAME: _____

	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:

_____