Welcome to Northport Podiatry P.C.

Denise Casinover-Raio, D.P.M

Elizabeth Haeni, D.P.M.

NAME_____ BIRTHDATE_____ SEX: M / F

ADDRESS_____CITY_____STATE_____ZIP_____

PHONES: HOME_____ WORK_____ CELL_____

SS#_____ MARITAL STATUS: S/ M /W /OTHER

SPOUSE/PARENT NAME_____ EMAIL_____

PATIENT EMPLOYER_____ OCCUPATION_____

PRIMARY INSURANCE

INSURANCE COMPANY_____

INSURANCE ID#_____ GROUP#_____

POLICY HOLDER_____ RELATIONSHIP TO PATIENT_____

POLICY HOLDER BIRTHDATE_____ EMPLOYER OF POLICYHOLDER_____

SECONDARY INSURANCE

INSURANCE COMPANY_____

INSURANCE ID#_____ GROUP#_____

POLICY HOLDER_____ RELATIONSHIP TO PATIENT_____

POLICY HOLDER BIRTHDATE_____ EMPLOYER OF POLICYHOLDER_____

IN EVENT OF EMERGENCY

Contact_____ Relation_____

Phone Number_____

Referred to our office by_____

REASON FOR VISIT

What is your current foot/ankle problem?(please describe the location)_____

_____

How long has this been a problem?_____

Have you had any treatment?_____

Have you had similar conditions in the past?_____ Explain_____

MEDICAL HISTORY

Do you have or have you had any of the following diseases or conditions? (please circle all that are relevant)

Y Diabetes	Y Shortness of Breath	Y Alcohol/ Drug Addiction
Y Poor Healing	Y Asthma	Y Hypothyroid/ Hyperthyroid
Y High/ Low Blood Pressure	Y Heart Attack/ Stroke	Y Arthritis Osteo/ Rheumatoid
Y Heart Surgery/ Pacemaker	Y Foot Ulcerations	Y Hepatitis, type A, B or C
Y Ankle/ Leg Swelling	Y Hypercholesterolemia	Y Anemia
Y Congenital Heart Defect	Y Circulation Problems	Y Cancer
Y Chemotherapy	Y Kidney Problems	Y Back Problems
Y Cramps Feet/ Legs	Y Fainting/ Seizures	Y Loss of Balance

Please list any other serious medical conditions_____

List previous Surgeries_____

Do you smoke?_____ How often?_____ Drink Alcohol?_____ How often?_____

Please list ALL medications you are currently taking. If you have a list, please provide to the receptionist so she can make a copy_____

_____

ALLERGIES_____

Primary Care Physician_____

Address_____ Phone_____

FAMILY HISTORY

In your family, any history of: Please list the relationship after the disease. Ex: mother/ father etc.

Heart Disease	_____	Kidney Disease	_____
High Blood Pressure	_____	Liver Disease	_____
Stroke	_____	Cancer (type?)	_____
Diabetes	_____	Rheumatic Disease	_____

AUTHORIZATIONS: **you must complete this section**

I authorize payment of medical benefits directly to Northport Podiatry, PC/ Denise Raio, DPM

I authorize the release of any medical information necessary to process my insurance claims.

I understand that I am responsible for any portion of my claims which are not covered by my insurance company. These charges may include but are not limited to annual deductibles, copayments, coinsurance and non-covered services. Payment must be in the form of cash, checks or FSA/HAS cards. No credit/debit cards.

Copayments not paid at the time of service are subject to a $5.00 charge. Any account turned over to a collections agent will be subject to a 25% increase.

I understand that I may be subject to a $25.00 fee for appointments missed or cancelled without 24 hour notice.

_____ _____ _____

Print Name Signature Date

NORTHPORT PODIATRY, P.C.

DENISE CASINOVER-RAIO, D.P.M.

HIPAA NOTIFICATION

Use and Disclosure:

Under HIPAA regulations, our office may use your medical information, without your expressed written consent or authorization when obtaining payment for our services. For example, we are permitted to supply your insurance company with a diagnosis code and description of services rendered.

Under this federal law, we are also allowed to provide your health information to a specialist that we are referring you to without your written consent. For example, sending blood work and laboratory results to the specialist is allowed.

Our office must request consent from you before sending any cultures/specimens to a specified laboratory/facility. Other uses or disclosures of medical information, will be made only with your written consent.

We may contact you by mail or phone, at your residence or at a telephone number provided, to remind you of appointments or to provide information regarding your care. Unless you instruct us otherwise, we may leave a message on any answering device or with any person who answers the phone at your residence. Please notify us below with any issues with this policy.

If you would like our office to use alternative methods of communication with you in a confidential manner, space for this is provided below.

You have the right to request copies of your medical records and radiographs (at the patient's expense) and to request an accounting of any disclosures we make of your medical information.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. Our office does not release any protected health information for marketing purposes.

If you feel that your rights are ever violated by our office, please voice your complaint to our Mary Moccia, our office manager and privacy practice manager.

I have reviewed this notice_____ _____

Signature Date

Special request for confidential communication:_____ _____

_____

_____

_____Initials