TOTAL FOOTCARE

GREG F. RUBINSTEIN, DPM, FACFAS, PA
Diplomate, American Board of Podiatric Surgery
MARC STRULOWITZ, DPM
Associate, American College of Foot and Ankle Surgeons

811 Grange Road
Teaneck, NJ 07666
Telephone: (201) 836-7173
Fax: (201) 836-0783

Patient's Personal Information

Today's date: _____

First name: _____ Middle name: _____

Last name: _____ Gender: ❑ Male ❑ Female

Social Security number: _____ Birth date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Preferred phone number: ❑ Home ❑ Work ❑ Cell Your occupation: _____

We must ask the following three questions to comply with Federal Government regulations:

1) Race:
- ❑ Not specified
- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ American Indian or Alaskan Native
- ❑ Native Hawaiian or Other Pacific Islander

2) Ethnicity:
- ❑ Not specified
- ❑ Not Hispanic or Latino
- ❑ Hispanic or Latino

3) Preferred language: _____

Marital status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Partner

Spouse's/Partner's name: _____

Emergency contact: _____ Relationship: _____

Emergency contact's phone number: _____

Whom can we thank for referring you? _____

Who is your employer? _____

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Patient's Billing/Insurance Information

Patient's primary insurance company and policy number: _____

If your primary insurance policy is not in your name please complete items 1 - 5 below:

1) Subscriber's first name: _____ 2) Subscriber's last name: _____

3) Subscriber's birth date: _____ 4) Patient's relationship to the subscriber: _____

5) Subscriber's Address: _____

Patient's secondary insurance company and policy number: _____

If your secondary insurance policy is not in your name please complete items 1 - 5 below:

1) Subscriber's first name: _____ 2) Subscriber's last name: _____

3) Subscriber's birth date: _____ 4) Patient's relationship to the subscriber: _____

5) Subscriber's Address: _____

It is our policy to collect all co-payments and outstanding balances prior to each visit

This practice accepts assignment from Medicare and most managed care plans. However, payments from these plans usually represent only partial payment for your treatment. You are responsible for all deductibles, co-payments, co-insurances, and noncovered charges.

I certify that the above information is true to the best of my knowledge. I assign all payments for my treatment by Dr. Greg F. Rubinstein from Medicare, Medicaid, HMOs, PPOs, and commercial insurance companies to this office.

Patient's signature: _____

If the patient is not responsible for paying for their treatment, please complete the section below:

Responsible individual's name: _____

Responsible individual's relationship to the patient: _____

Responsible individual's signature: _____

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Patient's Medical History PATIENT'S NAME:_____

Please answer the following questions about your general health:

Aids/HIV	❑ Yes	❑ No	Eye problems	❑ Yes	❑ No	Radiation treatment	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting	❑ Yes	❑ No	Rash	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatic fever	❑ Yes	❑ No
Artificial heart valves	❑ Yes	❑ No	Heart disease	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Artificial joints	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Sinus problems	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Special diet	❑ Yes	❑ No
Back problems	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Bleeding disorder	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Shingles	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Chemical dependency	❑ Yes	❑ No	Kidney problems	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Chest pain	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No	Varicose Veins	❑ Yes	❑ No
Chronic diarrhea	❑ Yes	❑ No	Low blood pressure	❑ Yes	❑ No	Venereal disease/Herpes	❑ Yes	❑ No
Circulatory problems	❑ Yes	❑ No	Nervous problems	❑ Yes	❑ No	Unexplained weight loss	❑ Yes	❑ No
Ear problems	❑ Yes	❑ No	Phlebitis	❑ Yes	❑ No	Elevated cholesterol	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	Psychiatric care	❑ Yes	❑ No	Thyroid	❑ Yes	❑ No

Other Illnesses:_____

Please answer the following questions about Diabetes in your family:
Do you have Diabetes? ❑ Yes ❑ No
If you answered yes, how old were you when Diabetes was diagnosed? _____
If you answered yes, when did you last see the doctor that is treating your Diabetes? _____

Is there a family history of Diabetes? ❑ Yes ❑ No
If yes, please describe the family member's relationship to you:_____

Please answer the following questions about your foot health:

Ankle pain	❑ Yes	❑ No	Foot or Leg Cramps	❑ Yes	❑ No	Numbness in legs	❑ Yes	❑ No
Athlete's foot	❑ Yes	❑ No	Heel pain	❑ Yes	❑ No	Plantar warts	❑ Yes	❑ No
Bunions	❑ Yes	❑ No	Ingrown toenails	❑ Yes	❑ No	Swelling in ankles or feet	❑ Yes	❑ No
Corns and calluses	❑ Yes	❑ No	Itchy Feet	❑ Yes	❑ No	Swollen neck glands	❑ Yes	❑ No
Flat feet	❑ Yes	❑ No	Numbness in legs	❑ Yes	❑ No	Tired feet	❑ Yes	❑ No

Smoking history:

❑ I smoke everyday
❑ I smoke occasionally
❑ I am a former smoker
❑ I Never smoked
❑ I do not want to answer

Please list any surgeries that you have had:_____

_____

Please list any hospitalizations, other than for the surgeries listed above: _____

_____

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Patient's Medical History continued

PATIENT'S NAME:_____

Who is your family physician: _____ Date Last Seen: _____

Are you now or have you been under any other doctor's care in the past two years? ❑ Yes ❑ No

If yes please explain: _____

_____

What is the reason for this visit? _____

_____

How long have you had this problem? _____

Do you exercise or participate in sports, please also include the frequency: _____

_____

Please list all medications, vitamins, and supplements that you currently take, use the back if necessary:

_____

_____

_____

_____

_____

_____

_____

Do you have any allergies? ❑ Yes ❑ No
If yes, please list all your allergies below:

_____

_____

_____

_____

_____

_____

_____

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Patient Confidentiality Agreement

I certify that the above information is true to the best of my knowledge. I give permission to the doctor to administer treatment and perform procedures as may be deemed necessary in the diagnosis and treatment of my ailments.

Please Print Patient's Name: _____

Patient's signature: _____

If you filled out this form for the patient please answer the following two questions and sign below:

Your name: _____ Your relationship to the patient: _____

Your signature: _____

I understand that as part of my treatment confidential medical information will be stored in this offices charting/billing system.

This information will be used to plan my care with other healthcare providers and insurance companies. It may also be sent to insurance companies or other entities to facilitate payment for treatment provided to you.

This office will not share your information with other individuals, except as required by law, without your written approval.

Please list the names and relationship for any person(s) that you permit this office to communicate with concerning your healthcare. If the answer is none please write NONE below.

_____

_____

_____

PRIVACY POLICY. I have read and understood the Offices "Notice of Privacy Policies". My rights including the right to see and copy my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the office has already made disclosures with my prior consent.

Your signature: _____

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Patient Pharmacy Information

Local Pharmacy:
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Mail Order Pharmacy:
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

PATIENT'S NAME _____