WELCOME TO THE OFFICE OF STEINWAY FOOT CARE GROUP, LLP

Please help us provide you with the proper Podiatric care by completing the following form.

NAME: _____ OCCUPATION: _____

YOUR PRIMARY DOCTOR: _____ DRS. PHONE: _____

DRS. ADDRESS: _____

PAST MEDICAL HISTORY

Please check if you have or have had any of the following:

____ DIABETES
____ HEART TROUBLE (Angina, Mitral Valve Prolapse)
____ HIGH BLOOD PRESSURE
____ RESPIRATORY (Breathing) PROBLEMS (Asthma, COPD)
____ STOMACH OR INTESTINAL DISORDER (Ulcer, Acid Reflux)
____ SKIN CONDITION (Psoriasis, Eczema)
____ CIRCULATION PROBLEMS (Cold Feet, Swelling, Pain in Calf)
____ BLOOD DISORDER
____ THYROID CONDITION
____ LIVER CONDITION
____ KIDNEY DISEASE
____ NERVOUS DISORDER
____ ARTHRITIS OR GOUT
____ HEPATITIS HISTORY

SOCIAL HISTORY

Do You Smoke? ____YES ____ NO If Yes How Many Packs per Day: _____
Do You Drink Alcohol? ____ YES ____ NO If Yes, ____ Socially Or ____ More Than Socially

MEDICATIONS

Please List All Meds Taken: _____

PAST HOSPITALIZATION AND/OR SURGICAL HISTORY

Have you ever been Hospitalized or had an Operation? ____ YES ____ NO

If Yes, When and for what reason? _____

ALLERGIES

Please check if you are Allergic to:

____ LOCAL ANESTHETICS (NOVOCAINE)
____ IODINE OR SHELLFISH
____ OTHER: _____
____ PENICILLIN
____ BANDAGE / TAPE
____ SULFUR
____ ASPIRIN
____ CODEINE

Have you ever been to a Podiatrist before?

What is the purpose of your visit today?

Who may we thank for referring you to our office?

Additional information you would like us to know:

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my Medical History, or if my Medications change, I will inform Steinway Foot Care Group, LLP at the next appointment. I herby authorize Steinway Foot Care Group, LLP to provide the needed Podiatric Treatment.

SIGNATURE TODAY'S DATE

STEINWAY FOOT CARE GROUP, LLP------ PATIENT INFORMATION FORM

DATE: _____ E-mail address_____@_____

LAST NAME: _____ FIRST NAME: _____ MI: _____

STREET: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ - _____ CELL PHONE: ( ) _____ - _____

BIRTHDATE: _____ / _____ / _____ AGE: _____ GENDER: Male / Female

SOCIAL SECURITY #:_____ - _____ - _____ MARITAL STATUS: S M D W

EMPLOYED? Yes / No STUDENT? Yes / No FULL-TIME or PART-TIME

EMPLOYER: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE :( ) _____ - _____ EXT: _____

GUARANTOR INFO – WHO IS RESPONSIBLE FOR THE PATIENT BILL

Fill out only if you are less than 18 years old

LAST NAME: _____ FIRST NAME: _____ MI: _____
STREET: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: ( ) _____ - _____ CELL PHONE: ( ) _____ - _____
BIRTHDATE: _____ / _____ / _____ AGE: _____ GENDER: Male / Female
SOCIAL SECURITY #:_____ - _____ - _____ MARITAL STATUS: S M D W
EMPLOYED? Yes / No STUDENT? Yes / No FULL-TIME or PART-TIME
EMPLOYER: _____
STREET: _____ CITY: _____ STATE: _____ ZIP: _____
WORK PHONE :( )_____ - _____ EXT: _____

WHO IS THE PRIMARY INSURANCE SUBSCRIBER? Self / Spouse / Parent / Other

Subscriber INFO--Who is the Insurance under--<u>Fill out only if not self</u>

POLICY #:_____ GROUP #:_____
LAST NAME: _____ FIRST NAME: _____ MI: _____
STREET: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: ( ) _____ - _____ CELL PHONE: ( ) _____ - _____
BIRTHDATE: _____ / _____ / _____ AGE: _____ GENDER: Male / Female
SOCIAL SECURITY #:_____ - _____ - _____ MARITAL STATUS: S M D W
EMPLOYER: _____
STREET: _____ CITY: _____ STATE: _____ ZIP: _____
WORK PHONE :( )_____ - _____ EXT: _____

Dear Patients, Due to the “Affordable Care Act" (Obama Care), the Government wants all Doctors to obtain specific information on all patients. The Government will now start to Fine all Doctors who do not comply. Please answer all questions below and ***Thank You for your help!***

Name:_____

Gender: Male / Female Date of Birth:_____

Email:_____@_____ or Do not have one

Mobile/Cell phone number: (_____) _____-_____ or Do not have one

Race: (Circle One Below)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other
Patient declined to specify

Ethnicity: (Circle One Below)
Hispanic or Latino
Not Hispanic or Latino
Patient declined to specify

Preferred Language:_____ Height:_____ Weight:_____

Past Medical History--Please ***check off*** if you have any of the medical issues below

AIDS/HIV		Diabetes		Hernia		Pulmonary	
Anemia		Dialysis		Hypertension		Raynaud's Disease	
Arthritis		Dyslipidemia		Kidney Disease		Rheumatoid Arthritis	
Artificial Joints		Edema		Leg or Foot Ulcers		Seizures/Epilepsy	
Asthma		Fibromyalgia		Liver Disease		Stroke	
Back Pain		Foot Deformity		Lung Disease		Substance Abuse	
Bleeding Disorder		Frost Bite		Organ Transplant		Thyroid Problems	
Blood Clot		Gout		Osteoporosis		Tuberculosis	
Cancer		Headaches		Pacemaker		Varicose Veins	
Coronary Artery Dis		Heart Disease		Peripheral Vascular			
Deep Vein		Hepatitis		Polio			

Any Relevant Family History?: _____

_____

All Prescriptions will go Electronically--Who is your Pharmacy: _____

Address: _____

Phone #: _____

Signature:_____ Date:_____

Steinway Foot Care Group, LLP
Dr. Jerome B. Glassmith^
Dr. James D. Einhorn*
Dr. Jill L. Einhorn*
Board Certified
American Board of Podiatric Surgery*
American Board of Primary Podiatric Orthopedics
& Primary Podiatric Medicine^
41-05 31st Avenue
Astoria, N.Y. 11103
Phone: (718) 278-8020
Fax: (718) 278-8599

Notice of Privacy Practices & Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient): _____

Steinway Foot Care Group, LLP

Dr. Jerome B. Glassmith^ Dr. James D. Einhorn* Dr. Jill L. Einhorn*

Board Certified

American Board of Podiatric Surgery*

American Board of Primary Podiatric Orthopedics

& Primary Podiatric Medicine^

41-05 31st Avenue, Astoria, N.Y. 11103

Phone: (718) 278-8020 Fax: (718) 278-8599

PATIENT'S AUTHORIZATION

SIGNATURE ON FILE

I hereby authorize the release of any medical and/or insurance information necessary to process any claims for services rendered by **Dr. James and/or Dr. Jill Einhorn and/or Dr. Jerome Glassmith, DPM's** the physicians rendering services to me. I hereby authorize the payment of my PRIMARY INSURANCE medical benefits to **Dr. James and/or Dr. Jill Einhorn and/or Dr. Jerome Glassmith, DPM's** the physicians rendering services to me. I further authorize the payment of my SECONDARY and/or MEDIGAP INSURANCE medical benefits if applicable to **Dr. James and/or Dr. Jill Einhorn and/or Dr. Jerome Glassmith, DPM's** the physicians rendering services to me. **Dr. James and/or Dr. Jill Einhorn and/or Dr. Jerome Glassmith, DPM's** the physicians rendering services to me will make all reasonable attempts to obtain payment from my insurance company. **However, if these attempts fail (due to termination of coverage, lack of full benefits to see specialists and/or my failure to obtain a proper and authorized referral, etc.) I realize that I will be responsible for the charges. Please note that as a courtesy we will do our best to obtain referrals and/or authorizations (to help our office run smoother), BUT if for some reason our office does not obtain it or forgets to ask you for it, this does not release you of your responsibility of knowing your Insurance requirements. We are not responsible to know your Insurance's Rules. Ultimately, you are responsible for any bills that your insurance does not cover. For this purpose, we require either a SOCIAL SECURITY NUMBER or Copy of your DRIVERS LICENSE on file.**

Signature Date

****** FOR MEDICARE PATIENTS ONLY (IF NEEDED) ******

Dr. James and/or Dr. Jill Einhorn and/or Dr. Jerome Glassmith, DPM's the physicians rendering services to me have advised me that the professional services to be furnished to me might not be covered by Medicare, as Medicare may not consider them covered services. Even though Medicare might not pay for this, I have advised **Dr. James and/or Dr. Jill Einhorn and/or Dr. Jerome Glassmith, DPM's** the physicians rendering services to me, to proceed, and I will assume the responsibility for payment to **Dr. James and/or Dr. Jill Einhorn and/or Dr. Jerome Glassmith, DPM's** the physicians rendering services to me.

Signature Date