Personal

Today's Date: _____

Name: _____

Date of Birth: _____

Address: _____

_____ Zip code _____ **Apt #_____**

Phone: *Home:* _____
Work: _____*Ext.*_____
*Cell:*_____

E-Mail address: _____

Who referred you? _____

Employer: _____

Primary Care Physician: _____

Address: _____

Phone: _____

Pharmacy: _____

Address: _____

Phone: _____

Preferred Language: _____

Race: _____

Ethnicity: *Choose one:*

___Hispanic or Latino ___Not Hispanic or Latino

___Prefer not to say

Insurance

Name of insured: _____

Relationship to insured: _____

Insured's Date of Birth: _____

Insurance Company: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Policy #: _____

Group #: _____

Medical History

Height: _____ Weight: _____

List all Medications & Doses:

_____
_____
_____

List any allergies that you have to medications, including latex, adhesives, intravenous dyes:

_____
_____
_____

List ALL medical problems:

_____
_____
_____
_____

List prior surgeries and approximate dates:

_____
_____
_____
_____

Pregnant or possibly pregnant? ____no ___yes

Social History

What type of work do you do?

_____

Is your job sedentary? _____

How do you commute? _____

Cigarette Smoking?

___yes How much? _____ How long? _____

___no, never smoked

___quit When?_____

Do you drink alcohol? _____

Exercise:

What type of exercise do you participate in on a regular basis? _____

_____

How many times a week do you exercise?

_____

NAME:_____

Shoes

Shoe size: _____

What type of shoe do you commute in? _____

What type of shoes do you wear at work? _____

_____

What brand and model sneaker do you exercise in? _____

What do you wear on your feet while at home?

_____

Chief Complaint

What is the chief complaint that brings you to our office for medical treatment? _____

_____

_____

Which side? _____

When did the problem begin? _____

Was the onset gradual or acute? _____

Describe your symptoms (i.e.: sharp, dull, burning, shooting, throbbing, piercing, sore, etc.) _____

_____

How frequently do you have symptoms? _____

_____

When symptoms occur, how long do they last?

_____

Have symptoms changed since you first noticed them? ___unchanged ___worsening ___improving

What treatments have you tried? _____

_____

Have you ever had a similar problem? When?

_____

List any other information that you think may be helpful or important: _____

_____

Runners only answer the following group of questions:

When did you start running? _____

Where do you run (be specific)? _____

_____

What is your weekly mileage? _____

Are you preparing for a particular event? _____

_____

What brand and model shoes do you run in?

_____

When does your current condition hurt? (Check all that apply)**:**

_____ **During the run**

From the start?_____

_____ **After the run**

How long does it last? _____

_____ **All the time**

Have you had any other running related injuries?

_____

Do you wear custom made foot orthotics?

_____yes _____no

Do you use over the counter shoe inserts? _____

Lori S. Weisenfeld, DPM
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Diplomate, American Board of Podiatric Surgery
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212-947-2320

AUTHORIZATION FOR PAYMENT

I hereby authorize payment of insurance benefits to be made to Lori S. Weisenfeld, DPM for any services furnished to me by her. I authorize any holder of medical information about me to release any and all information needed to determine these benefits payable for related services. Furthermore, I understand and agree that I am ultimately responsible (regardless of my insurance status) for the balance on my account for any professional services rendered and that possessing the above insurance information is not a guarantee of coverage.

I have read all of the information on this form and answered all questions to the best of my knowledge. I will notify this office of any changes in my health status or changes in the information provided.

_____ _____

Print Name or Authorized Representative Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 so I so chose) and understood the Notice.

_____ _____

Print Name or Authorized Representative Signature Date

MANAGED CARE INSURANCE PLANS

If you have a Managed Care type of insurance that requires a referral for each office visit, it is your responsibility to obtain this before your visit. If you have not received the proper authorization, you will either not be seen or you will be responsible for the entire fee.

I have read and understand the Office Policies regarding Managed Care Insurance Plans.

_____ _____

Print Name or Authorized Representative Signature Date