Syracuse Podiatry
7075 Manlius Center Road
East Syracuse, NY 13057
(315) 446-FOOT (3668)
FAX: (315) 849-1182
www.syracusepodiatry.org

PATIENT INFORMATION

First Name _____ Middle Initial ___ Last Name _____ Suffix ____

Date of Birth _____ Gender ☐ M ☐ F Social Security # _____-____-_____

Address _____ City_____ State____ Zip Code _____

Phone Number **(**_____**)**_____Cell Phone **(**_____**)**_____ Carrier_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

EMPLOYMENT INFORMATION

Employer _____ Job Title _____

Address _____City _____ State_____ Zip Code_____

Phone Number **(**____**)**_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Unemployed

EMERGENCY CONTACT

Name_____Relationship to Patient**:**_____ Phone Number**(**_____**)**_____

INSURANCE INFORMATION

Primary Policy:

Insurance Carrier _____

ID/Policy Number _____

Name of Policy Holder _____

Date of Birth of Policy Holder _____

Relationship to Patient _____

Secondary Policy:

Insurance Carrier _____

ID/Policy Number _____

Name of Policy Holder _____

Date of Birth of Policy Holder_____

Relationship to Patient _____

VISIT REASON

Why are you seeing the doctor today? _____

Is there pain associated with this condition? ☐ Yes ☐ No

What causes or aggravates the pain? _____

What works best to relieve the pain? _____

Any additional factors you would like to mention? _____

Whom may we thank for your referral today? _____

Primary Care Physician (**PCP**): _____ **Date of Last PCP Visit**: _____

Pharmacy Information: _____ **Location**_____

Shoe Size:_____

ALLERGIES

1. Please indicate all allergies to medications:

☐ No Known Drug Allergies

Medication	Reaction	Medication	Reaction
_____		_____	
_____		_____	

Other Allergies: ☐ Adhesives ☐ Band Aids/Tape ☐ Gloves ☐ Latex

2. Do you have any complications due to Anesthesia? ☐ Yes ☐ No Describe _____

MEDICATIONS

Please include prescriptions, over the counter, vitamins and supplements.

– **You may also submit a current medication list,** for your convenience.

Medication	**Dosage**	**Frequency**	**Medication**	**Dosage**	**Frequency**
_____			_____		
_____			_____		
_____			_____		
_____			_____		

PAST MEDICAL HISTORY

Please CHECK any conditions that currently apply OR that you have experienced in the past:

Constitutional/General
- ☐ Cancer Type:_____
- ☐ Elevated Temperature
- ☐ Night Sweats

Cardiovascular
- ☐ Angina
- ☐ Blood Clots/DVT
- ☐ Easy Bruising/Bleeding

Heart Attack
- ☐ Hypertension
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ Rheumatic Fever
- ☐ Valve Problems

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sleep Apnea/C PAP

Infectious Disease
- ☐ HIV /AIDS

STDs

Tuberculosis/TB

Gastrointestinal
- ☐ Acid Reflux/ GERD
- ☐ Gall Bladder
- ☐ Hiatal Hernia
- ☐ IBS
- ☐ Stomach/Bowel Problems
- ☐ Ulcers

Genito-Urinary
- ☐ Bladder or Kidney Stones
- ☐ Infection
- ☐ Kidney Failure
  - ☐ Dialysis
- ☐ Prostate Disease

Endocrine
- ☐ Heat or Cold Intolerance
- ☐ Diabetes
- ☐ Hyperthyroid
- ☐ Hypothyroid

Hematologic Disease
- ☐ Anemia Type: _____
- ☐ Sickle Cell

Liver
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Jaundice

Vision
- ☐ Double/Blurred Vision
- ☐ Glaucoma
- ☐ Hearing Deficit/Loss
  - ☐ Hearing Aid
- ☐ Macular Degeneration
- ☐ Vision Changes
  - ☐ Contacts/Glasses ☐

Nervous System
- ☐ Anxiety
- ☐ Depression
- ☐ Convulsions/Epilepsy
- ☐ Fainting
- ☐ Memory Loss
- ☐ Migraines
- ☐ Muscle Weakness
- ☐ Muscular Dystrophy
- ☐ Muscular Sclerosis
- ☐ Stroke
- ☐ Neuropathy
- ☐ Parkinson's Disease
- ☐ **Other**: _____
  _____ ☐
  _____ ☐
  _____

SOCIAL HISTORY

1. Do you currently smoke or chew tobacco? ☐ YES ☐ NO
How many packs/cans per day?_____ How many years? _____
If NO, have you in the past? ☐ YES ☐ NO For how many years? _____

2. Do you drink alcohol? ☐ YES ☐ NO How many glasses/drinks per day? _____

3. Do you drink caffeine? ☐ YES ☐ NO How many cups/drinks per day? _____

4. Do you use any illicit drugs (i.e. marijuana, cocaine, heroin, etc.)? ☐ YES ☐ NO
If yes, which drugs? _____
If no, have you in the past? ☐ YES ☐ NO Which drugs? _____

SURGICAL HISTORY:

Please List Any Surgeries **AND** Year:

_____

_____

_____

_____

_____

FAMILY HEALTH HISTORY:

Mother:_____
Father:_____
Siblings:_____
Children:_____
Maternal Grandparents:_____
Paternal Grandparents:_____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to it's terms.

Name of Patient	Date of Birth	Signature of Patient/Representative	Date

II. Designation of Certain Relatives, Close Friends and/or Caregivers as my Personal Representative:
I agree that the practice may disclose parts of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, the Physician/Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name: _____ DOB or Other Identifier: _____

Print Name: _____ DOB of Other Identifier: _____

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home Telephone Number:

☐ Okay to leave a message with detailed information **- OR -** ☐ Leave message with call back number only

Work Telephone Number:

☐ Okay to leave message with detailed information - **OR** - ☐ Leave message with call back number only

Cell Telephone Number:

☐ Okay to leave message with detailed information - **OR** - ☐ Leave message with call back number only

EMAIL: _____ ☐ Okay to email address Practice has on file

****

1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any recovation.
4. If you request it, a copy of the information described in this form can be obtained at the front desk.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

IV. Assignment of Benefits:
I hereby assign directly to Dr. Ryan D'Amico, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. Patient or responsible party agrees to pay any and all costs of collection and/or attorney fees required to settle account. I authorize the use of this signature on all my insurance submissions. I hereby authorize the release of all information necessary to secure the payment of benefits. In order to insure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to a designated referral provider and/or physician.

Signature of Patient OR Patient Representative	**Date**