



# WELCOME



## PATIENT INFORMATION

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail \_\_\_\_\_  
Sex ☐ M ☐ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
☐ Married ☐ Widowed ☐ Single ☐ Minor  
☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years  
Patient Employer/School \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance? ☐ Yes ☐ No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies) \_\_\_\_\_  
and assign directly to Dr. \_\_\_\_\_  
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

### MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to \_\_\_\_\_  
Name of \_\_\_\_\_  
\_\_\_\_\_ for any services furnished to me by that provider.  
Doctor or Clinic \_\_\_\_\_

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Please print name of Beneficiary, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Beneficiary \_\_\_\_\_

## PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been to a Podiatrist before?  
☐ Yes ☐ No

If yes, please list.

Name \_\_\_\_\_  
Last visit \_\_\_\_\_

Is there any personal or family history of diabetes?  
☐ Yes ☐ No

Your occupation \_\_\_\_\_

Cigarette/Tobacco use \_\_\_\_\_

Years smoked \_\_\_\_\_

Athletic activities in which you participate  
(please list and indicate frequency)  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bunions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corns and Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cramps or Numbness in Feet or Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flat Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plantar Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in Ankles or Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No

## MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Surgeries you have had \_\_\_\_\_

Hospitalization other than for the surgeries listed \_\_\_\_\_

Family physician \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain \_\_\_\_\_

### MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) (\_\_\_\_) \_\_\_\_\_

Do you take oral contraceptives? ☐ Yes ☐ No

### ALLERGIES

<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
Other _____	

### TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient



# PATIENT MEDICATION LIST

Today's Date \_\_\_\_\_

Patients Name \_\_\_\_\_ DOB \_\_\_\_\_

## MEDICATIONS

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.

Over-the-counter medications	Dose	How often taken

## HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

For older adults, have you received the pneumonia (pneumococcal) vaccination?

No \_\_\_\_\_ Yes \_\_\_\_\_ Date Received \_\_\_\_\_

CRYSTAL PODIATRY – DR. RAYMOND OLIVIERO, DPM

**HIPAA OMNIBUS RULE**  
**PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation       | <input type="checkbox"/> Email Confirmation      |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation       | <input type="checkbox"/> <b>Any of the Above</b> |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation       | <input type="checkbox"/> Email Confirmation      |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation       | <input type="checkbox"/> <b>Any of the Above</b> |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- |  |   |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the Above</b> (opt out) |
| <input type="checkbox"/> Email         |   |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
Please *print* name of Patient

\_\_\_\_\_  
Please *sign* Patient / Guardian of Patient

\_\_\_\_\_  
Legal Representative / Guardian

\_\_\_\_\_  
Relationship of Legal Representative / Guardian

**OFFICE USE ONLY**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment  
☐ I could not communicate with the patient  
☐ The patient refused to sign  
☐ The patient was unable to sign because  
☐ Other (please describe) \_\_\_\_\_

Signature of Privacy Officer \_\_\_\_\_