Practice: Kotkin, Ostroff & Morris D.P.M., P.C.

Name: _____ **DOB:** _____ **Today's Date:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name**: _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend

Shoe Size: _____ ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other (*specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking	☐fever	☐ chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐ palpitations	☐vascular disease	☐valve problems	☐**NONE**
Genitourinary	☐blood in urine	☐hesitancy	☐incontinence	☐increased urgency	
	☐decreased frequency	☐excessive urination	☐kidney disease	☐kidney stones	☐**NONE**
Gastrointestinal	☐abdominal pain	☐heartburn	☐blood in stool	☐vomiting	☐ulcers ☐constipation
	☐diarrhea	☐trouble swallowing	☐decrease appetite	☐increase appetite	☐**NONE**
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin ☐**NONE**
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders ☐**NONE**
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			☐**NONE**
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis ☐**NONE**
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			☐**NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Preferred Language: _____ ☐ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: _____

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Advanced Directives: ☐ Living Will ☐ DNR ☐ Durable Power of Attorney ☐ Surrogate Appointed ☐ None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Drs Michael Kotkin, Lawence Ostroff and Alan Morris, D.P.M.,PC
70 Glen Street, Suite 300
Glen Cove, NY 11542
Tel: 516-676-1116/0557 Fax: 516-676-2710

HIPAA WAIVER

I, _____ acknowledge that I have been provided with a copy of the privacy notice from the office of:

Drs Kotkin, Ostroff and Morris, D.P.M., PC

Signature: _____ Date:___/___/___

List of names that the group may discuss your care with:

_____

_____

_____

_____

Drs Michael Kotkin, Lawrence Ostroff and Alan Morris, D.P.M.,PC
70 Glen Street, Suite 300
Glen Cove, NY 11542
Tel: 516-676-1116/0557 Fax: 516-676-2710

AUTHORIZATION FORM

Dear Patient:

Please take a few minutes to read the following information. With today's constantly changing insurance regulations, this may apply to you.

You may need written authorization from your Primary Care Physician to be examined.

You may need written authorization from your Primary Care Physician for all follow-up visits.

- IT IS YOUR RESPONSIBILITY TO OBTAIN THIS AUTHORIZATION
- YOU MUST BE AWARE OF THE NUMBER OF VISITS ALLOWED AND THE DATE OF EXPIRATION.

You may need authorization from your Primary Care Physician, this office or directly from your insurance company for any of the following procedures ordered by our physicians:

- Physical Therapy, MRI, CT Scan, Blood Tests, Bone Scan, etc.,

Most insurance companies DO NOT PAY FOR durable goods for example: Splints, Aircasts, Orthotics & Braces along with Routine Foot Care and other non-covered services. Payment of these is the responsibility of the PATIENT.

We will do our best to try and help you comply with all the new regulations. Please do not hesitate to ask which of these applies to you.

I have read and understand the above information.

Signature: _____ Date: ___/___/___

Drs Michael Kotkin, Lawrence Ostroff and Alan Morris, D.P.M.,PC
70 Glen Street, Suite 300
Glen Cove, NY 11542
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FINANCIAL POLICY

Welcome to our Podiatry Group, our office is committed to providing the best care possible and appreciates your trust. Please take your time to review the following information.

Drs Kotkin, Ostroff and Morris will gladly submit claims to your insurance carrier. Please remember that co-pays are due at the time of service. If you are unable to pay at time of service there will be a $10 administration fee applied to your account for non-payment. For HSA or higher deductible accounts, balances must be paid at the end of the billing period.

We accept cash, checks and major credit cards. Although payment is required at the time of service, if you are unable to pay – prior arrangements can be made with the billing coordinator. For Established/Non-Established Private Pay patients a $60 deposit is required if unable to pay in full at the time services are rendered.

PAYMENT PLANS: Patients who have committed to a payment plan with the billing coordinator and fail to pay the monthly amount agreed upon by both parties are subject to a $10 billing administration fee. If you miss two or more payments, your payments will automatically be sent to a collections agency, and your previous payment plan agreement will be void.

If you have health insurance, please understand that this is an agreement between you and your insurance company; and you are responsible for knowing your benefits. We will be happy to assist you in any way we can, but you are ultimately responsible for timely payment to your account.

Drs Kotkin, Ostroff and Morris take many steps to avoid collections. However, if your account is placed with a collection agency you will be assessed a $100 collection fee. This will be added to your final balance placed with the collection agency and you will be responsible for all legal fees and court costs involved.

In the event of a divorce situation, we do understand your difficulties and we hope you understand a divorce decree is a document that involves you, your ex-spouse and the courts. Although a divorce decree may state that an ex-spouse is responsible for all medical bills, we have no authority to enforce compliance. Therefore, should the guarantor fail to pay the balance due after two billing cycles, the balances due will be the custodians responsibility.

If you present a check to this group that is not honored by your bank, a $40 non-sufficient funds charge will be added to your account per occurrence.

If you are unable to keep your appointment, we require 24 hours notice for cancellation. Failure to do so will result in a $25 missed appointment fee per appointment which will be charged to your account.

Failure to comply with our Financial Policies may result in dismissal from our practice. Thank you.

Signature: _____ Date: ___/___/___