

THE CENTER FOR PODIATRIC CARE & SPORTS MEDICINE

Dr. Josef J. Geldwert, DPM
Dr. Katherine M. Lai, DPM
Dr. Ryan Minara, DPM
Dr. Mariola Rivera, DPM

PATIENT INFORMATION SHEET

Name: _____ Birth Date: _____ Social Security#: _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip Code: _____

Gender: Male Female Home Phone#: _____ Business Phone#: _____

Cell Phone#: _____ Email: _____

Please check preferred method of communication: Home phone Work phone Cell phone Email:

Would you like text appointment reminders through your cell phone? Please let us know your cell carrier: _____

Marital Status: Single Married Divorced Widowed Other

Occupation: _____ Employer: _____

Referred by _____ Previous Podiatrist/Phone: _____

Primary Care Doctor: _____ Phone#: _____

Primary Insurance: _____ Phone#: _____

Policy# _____ Grp#: _____

Policy Holder: _____ Date of Birth: _____ SS#: _____

Relationship to Insured: Self Spouse Child Other

Type of Insurance: Private Worker's Comp No-Fault

Secondary Insurance: _____ Phone#: _____

Policy# _____ Grp#: _____

Policy Holder: _____ Date of Birth: _____ SS#: _____

Relationship to Insured: Self Spouse Child Other

Type of Insurance: Private Worker's Comp No-Fault

Authorization/Responsibility Agreement

I hereby authorize my insurance company to pay the proceeds of any benefits to the doctors of this office. I understand that I am responsible for any outstanding balance in accordance with my plan and that I will provide proper authorization or referrals for all my visits that may be required by my insurance plan. If I have not provided that which is required by my insurance plan, I agree to pay any outstanding balances directly to this practice. A copy of this can be considered an original for insurance purposes. _____ (Signature)

I understand that the doctor **does not** participate with my insurance plan and therefore I am financially responsible for the medical care received. _____ (Signature)

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I may request a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the notice. _____ (Signature)

I authorize any holder of medical information concerning me to release to my Insurance carrier or Health Care Financing Administration and its agents any information needed to determine these benefits or benefits of related services.

Print Name _____ Signature _____ Authorized Representative _____ Date _____

NAME: _____

MEDICAL INFORMATION

Height _____ Weight _____

Do you have or have you had any of the following (? = Do not know)

	Y	N	?		Y	N	?		Y	N	?
Foot/Leg Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Leg Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of Arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unequal Leg Length	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flat Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Arches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toe Nail Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bunions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Skin Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hammer Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								Raynaud's/Cold Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List any medical conditions not mentioned above, _____

List any previous surgeries. _____

List any allergies to medications, foods or other (please list)

List current medications. _____

Do you now, or have you in the past, smoke? Yes No If yes, how often? _____

Do you now, or have you in the past, drink alcohol? Yes No If yes, how often? _____

Pharmacy Phone Number** (Important. Please provide what info you have):

Name: _____ Phone #: _____

Zip Code: _____ Address/Cross Streets: _____

Chief reason for visit today: _____

Activities You Participate In:

- Walking
- Running
- Triathlon
- Biking
- Swimming
- Hiking
- Golf
- Aerobic Machine
- Aerobic Class
- Dance
- Pilates
- Yoga
- Weights
- Basketball
- Football
- Soccer
- Volleyball
- Field Hockey
- Lacrosse
- Baseball
- Other _____

THE 
CENTER FOR 
PODIATRIC CARE AND
SPORTS MEDICINE 

JOSEF J. GELDWERT, DPM, FACFAS
KATHERINE M. LAI, DPM, FACFAS
RYAN MINARA, DPM
MARIOLA RIVERA, DPM

I, _____, have requested treatment from Dr. Geldwert, Dr. Lai, Dr. Minara, and Dr. Rivera.
I have read and understand the following:

1. I am responsible for all co-payments, deductibles, and co-insurances as per the terms of my contract with my insurance carrier.
2. All co-payments must be paid at the time of service. This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e., for injections or x-rays).
3. I am responsible for obtaining any and all required referrals for service.
4. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
5. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
6. The office is restricted to a "timely filing period". I understand that I must supply the office with my health insurance information in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.
7. Fees associated with orthotic casting, prepared at my request, are my responsibility. Should I choose to stop the process of making the orthotics, I am still responsible for these fees, once the cast as been taken.
8. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office's financial institution. This current rate may be obtained by calling the Billing Manager at (212)996-1900.

Patient Signature

Guardian Signature if applicable

Date Signed