Cinnaminson Podiatry Group

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Name:_____
Last First Middle
Address: _____
City:_____ State:_____ Zip Code:_____
Date of Birth:_____ Gender: M / F SSN:_____
Phone Number: Cell- _____ Home -_____
Email: _____
Would you like text or email reminders? YES / NO Circle One: TEXT EMAIL
How did you hear about us? _____

Primary Care Physician: _____ Date Last Seen:_____

Primary Insurance Company:_____
Policy Holder Name/Relationship to Patient:_____
ID #_____ Group#_____
Policy Holder Date of Birth:_____Address:_____
Co-Payment :_____ Referral Required: YES / NO

Secondary Insurance Company:_____
Policy Holder Name/Relationship to Patient:_____
ID #_____ Group#_____
Policy Holder Date of Birth:_____Address:_____
Co-Payment :_____ Referral Required: YES / NO

I authorize Cinnaminson Podiatry Group to evaluate me and treat me as necessary for the conditions that I present to this office. I also authorize this office to process insurance claim forms on my behalf. I authorize the insurance company to remit payments for services rendered directly to this office. I agree to pay any copayments, deductibles, or non covered charges to this office.

Patient Signature:_____ Date:_____

Representative Signature:_____ Date:_____

MEDICAL QUESTIONAIRE

CHIEF COMPLAINT:_____

CURRENT MEDICATIONS: (**IF YOU HAVE A LIST WE CAN MAKE A COPY**)

_____

_____

_____

PHARMACY NAME/ LOCATION:_____

ALLERGIES:_____

ALLERGIES TO **LATEX**: YES / NO **TAPE**: YES/ NO **IODINE:** YES/NO
SHELLFISH: YES/ NO **METALS:** YES/NO **JEWELRY:** YES / NO

MEDICAL PROBLEMS/ PREVIOUS HOSPITALIZATIONS:_____

_____

PAST SURGERIES:_____

FAMILY HISTORY OF: (CIRCLE ALL THAT APPLY) DIABETES HEART DISEASE CANCER
BLOOD CLOT/DVT OTHER:_____

DO YOU SMOKE? (CIRCLE) NO YES HOW OFTEN?_____ FORMER SMOKER
NO YES
CIGARETTES PER DAY?_____

DRINK ALCOHOL? (CIRCLE) NO YES HOW OFTEN?_____

SOCIAL HISTORY: SINGLE / MARRIED / DIVORCED / WIDOWED

REVIEW OF SYSTEMS: (CIRCLE ALL THAT APPLY) ANY RECENT:

FEVER	CHILLS	NAUSEA/VOMITTING	CHEST PAIN	DIARRHEA
SHORTNESS OF BREATH		HEART PALPATATIONS	CONSTIPATION	DIZZINESS
DIFFICULTY URINATING		MUSCLE WEAKNESS	PARALYSIS	RECENT FALLS
NUMBESS/TINGLING		LOSS OF CONSCIOUSNESS		

PHYSICAL EXAM:
HEIGHT: _____ft_____in WEIGHT:_____LBS

WHERE DO YOUR FEET HURT?_____
HOW LONG HAVE THEY BEEN HURTING?_____
DOES ANYTHING MAKE IT FEEL BETTER?_____

PRIVACY NOTICE

It is the policy of Cinnaminson Podiatry Group (CPG) and staff to preserve the integrity and confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that this practice has the necessary medical and PHI to provide the highest quality care possible while protecting the confidentiality of the PHI of our patients. Information provided to this practice is for the purpose of treatment, payment, and healthcare operations. The well being of our patients is the most important priority. To that end CPG and staff will:

Adhere to the standards set forth in the Notice of Privacy Practices.

Collect, use, and disclose PHI only in conformance with state and federal laws and current patient covenants and / or authorizations as appropriate.

Recognize the PHI collected about patients must be accurate, timely, complete and available when needed.

Recognize that patients have a right to privacy. CPG and staff will act as responsible information stewards and treat PHI as sensitive and confidential. We will not disclose PHI data unless the patient has properly consented to or authorized the release or law otherwise authorizes the release.

We will permit patient's access to their medical records when Dr. Eugene V. Timpano or Dr. Eugene D. Timpano approves their written requests. We will provide patients an opportunity to request the correction of accurate or incomplete PHI in their medical records in accordance with the law and professional standards.

I have read this Privacy Notice and understand its contents.

_____ _____

Patient Signature Date