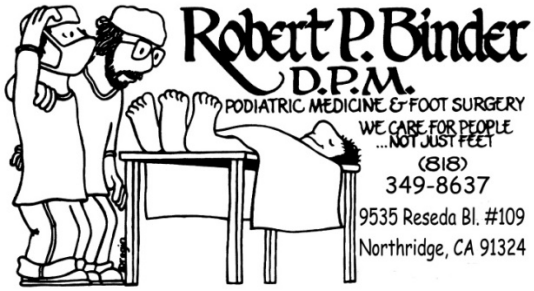


Patient Name: _____

Address: _____

Street City State Zip Code

Date of Birth: _____ **Age:** _____ **Social Security #:** _____-____-_____ **Full Time Student** ☐Y ☐N

****It is our practice to call or e-mail appointment reminders. It may also be necessary for our office to contact you for purposes of detailed medical and financial information. I authorize the practice to contact me by the following:**

Home phone: (____) ____-_____ Cell (___) ____-_____ Email:_____

Employer: _____ **Occupation:** _____ **Work Phone: (___) ____-_____**

Please list any restrictions concerning your being contacted at the above numbers:

_____

Name of Spouse/Parent/Other Emergency Contact: _____

Relationship: _____ **Phone #1: (___) _____-_____ Phone #2: (____) ____-_____**

How did you select our office: (Please check all that apply)

☐Primary Dr. ☐Insurance ☐Website ☐Internet ☐Yellow Pages ☐Friend/Family Name: _____

Name of Primary Physician: _____ **Phone: (____) _____-_____**

Pharmacy Name/Location: _____ **Phone: (_____) ____-_____**

Primary Insurance: _____ **Secondary Insurance:** _____

Only the disclosed insurances will be billed. It is the patient's responsibility to notify us of any changes to their insurance or policy benefits. Does your insurance require a referral: ☐yes ☐no

I hereby authorize Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery, to release any information acquired in the course of my examination or treatment, photocopies of this form will be as valid as the original, and that medical photographs may be taken in the course of treatment. Payment is expected when services are rendered, unless other arrangements are made in advance. I hereby authorize payment directly to Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery, of the amount due me in my pending claim for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me.

Signature of Patient or Legal Guardian: _____ **Date:** _____

If Not Patient, Relationship and Printed Name: _____

History of Present Illness

Patient Name: _____ **Date:** _____

1. Please describe the reason for your visit today:

   _____

   _____.

2. Please give the location of your symptoms: (example.. right great toe, left heel, etc.)

   _____

3. Approximately when did the symptoms start: _____

4. Describe your pain: (check all that apply)

   ☐burning ☐stinging ☐throbbing ☐aching ☐numbness ☐other: _

   ☐worse in AM ☐worse in PM ☐time of day not a factor

   ☐worse at rest ☐comes and goes ☐worse when standing/walking

   ☐getting worse ☐getting better ☐about the same since onset

5. Describe any influencing factors such as previous surgery, possible injury, or accident:_____

   _____.

6. Have you seen another doctor for this condition?

   ☐Primary Dr. ☐Podiatrist ☐ Orthopedic ☐Other: _____

   Were x-rays/MRI taken: ☐Yes ☐No

7. What were their recommendations for the care and how did the condition respond?

   _____

8. Please describe any home remedies or treatment, and indicate if they were of help or not:

   _____

9. Please describe any family member's similar foot problems, and list their relationship to you:

   _____

10. If you have ever seen a podiatrist, had a childhood foot problem, or previous surgery, please list the date and give details:

    _____

    _____.

Past Medical History: Chronic or Serious Illnesses

(Please check all that you have a history of):

☐Anti-Coagulation Therapy (Coumadin)
☐Arthritis, Rheumatoid
☐Arthritis, Osteo
☐Asthma
☐Back Pain
☐Congestive Heart Failure
☐Coronary Artery Disease
☐Depression/Anxiety
☐Diabetes, Type I
☐Diabetes, Type II
☐Glaucoma
☐Gout
☐High Blood Pressure
☐Kidney Disease
☐Liver Disease
☐Peripheral Vascular Disease
☐Phlebitis
☐Respiratory Disorders (COPD, Ephysema)
☐Stomach Ulcers
☐Other: _____

Major Surgeries/Operations: (please indicate approximate year)

Name of surgery: _____ Year: _____

Social History:

Marital Status: ☐Single ☐Married ☐Widow ☐Divorced

Children: #_____ Boys #_____ Girls ☐No Children

Exercise:

☐None ☐Occasional walking ☐Regular Walking ☐Running
☐Gym Workout ☐Swimming ☐Biking
☐Other: _____

Alcohol: ☐None ☐Former Drinker ☐Rare ☐Social

Smoking: ☐None ☐Former Smoker ☐Current Smoker

Family History

(Please check all that you have a family history of):

☐Alcoholism
☐Arthritis
☐Cancer(type)_____
☐Depression
☐Diabetes
☐Gout
☐Heart Disease
☐Hypertension
☐Stroke

Medications

Patient Name: _____ Date: _____

☐**Please check if you do not take any medications or herbal supplements.**

Please list any prescriptions and over the counter medicines, including herbal supplements and vitamins you take.

Medication Name:	# Taken	How Often	Oral/Topical, Inject?	Reason

☐ **See back for additional medications**

Allergies-Please check known allergies and describe the reaction

☐No Known Allergies

✓	Medication	Reaction (i.e. rash, fever, vomiting, GI upset, hives)
	Penicillin	
	Aspirin	
	Demerol	
	Codeine	
	Sulfa	
	Tetanus	
	Tape	
	Iodine	
	Local Anesthetics	
	Other:	

Review of Systems

Patient Name: _____ Date: _____

Do you currently have or are you being treated for:

General:

Fever or chills	☐No ☐Yes
Unexplained weight loss	☐No ☐Yes

Cardiovascular:

Chest pain or palpitations	☐No ☐Yes
Lower extremity edema or Swelling	☐No ☐Yes
Experience thigh or leg pain when walking distances	☐No ☐Yes

Respiratory:

Cough	☐No ☐Yes
Shortness of Breath	☐No ☐Yes
Wheezing	☐No ☐Yes

Gastrointestinal:

Diarrhea	☐No ☐Yes
Nausea	☐No ☐Yes
Constipation	☐No ☐Yes
Blood in Stools	☐No ☐Yes
Abdominal pain	☐No ☐Yes

Musculoskeletal:

Back pain	☐No ☐Yes
Joint pain or swelling	☐No ☐Yes
Muscle pain	☐No ☐Yes

Skin:

Rash	☐No ☐Yes
Bothersome skin lesions	☐No ☐Yes
Slow healing wounds	☐No ☐Yes

Neurological:

Headaches	☐No ☐Yes
Numbness or tingling	☐No ☐Yes
Gait instability	☐No ☐Yes
Difficulty Speaking	☐No ☐Yes
Confusion	☐No ☐Yes
Seizures	☐No ☐Yes

Psychiatric:

Anxiety	☐No ☐Yes
Depression	☐No ☐Yes

Hematologic/ Lymphatic:

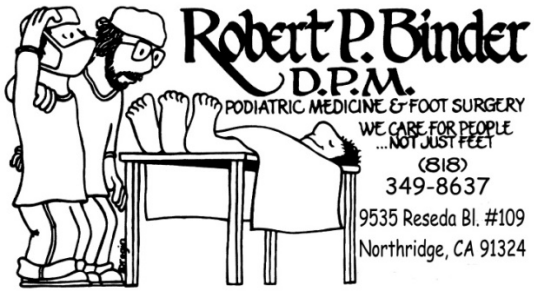
Easy bruising or bleeding	☐No ☐Yes
Swollen glands	☐No ☐Yes

Allergic/ Immunologic

Itchy / Watery eyes	☐No ☐Yes
Recurrent infections	☐No ☐Yes

Endocrine:

Frequency in urination	☐No ☐Yes
Sweating	☐No ☐Yes
Excessive thirst	☐No ☐Yes
Cold / heat intolerance	☐No ☐Yes



Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery
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Phone: (818) 349-8637 Fax: (818) 349-8306
www.feetbiz.com

Summary of Notice of Privacy Practice

This summary is provided to help you understand the Notice of Privacy Practices and describes how medic al information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully, the privacy of your medical information is important to us.

OUR LEGAL DUTY: We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give your this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow pthe privacy practices that are described in this notice while it is in effect. This notice takes effect 12/01/2018, and will remain in effect until we replace it. Copies of our complete notice of privacy practices, which contains a detailed description of how our office will protect your health care information, are located in the reception area and each treatment room. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION: We will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training.

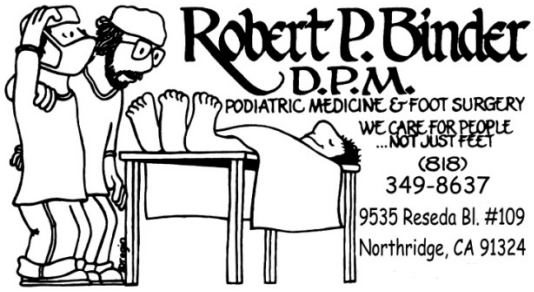
USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION: Except as stated in more detail in the notice of privacy practices, we will not use or disclose your health information without your written authorization.

USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION: In the following circumstances, we may disclose protected health or financial information without your written authorization:

To family members or close friends who are involved in your health. For certain limited research purposes. For purposes of public health and safety. To government agencies for purposes of their audits, investigations, and other oversight activities. To government authorities to prevent child abuse or domestic violence. To FDA to report product defects or incidents. To law-enforcement authorities to protect public safety or to assist in apprehending criminal offenders. When required by court orders, search warrants, subpoenas, and as otherwise required by the law.

AS OUR PATIENT YOU HAVE THE FOLLOWING RIGHTS: To have access to and or a copy of your health information. To receive an accounting of certain disclosures we have made of your health information. To request restrictions as to how your health information is used or disclosed. To request that we communicate with you in confidence. To request that we amend your health information. To receive notice of our privacy practices.

If you have any questions, concerns or complaints regarding our privacy practices, please refer to our detailed Notice of Privacy Practices or contact a staff member.



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Summary of Notice of Privacy Practice (continued)

Patient Name (please print): _____ Date of Birth: _____

** All signatures below are the patient's unless the patient is unable to understand or sign. If a legally authorized representative is signing for the patient, please also print name and state relationship.
By signing each section you are stating you fully understand and agree to that section of this document.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery prior to my signing this, and that I have read or had the opportunity to read if I so choose and understand the notice.
Patient Signature: _____ **Date:** _____

Consent for Medical and Billing Records Access

I allow (Patient Designee) _____ (relationship) _____
To have access to my medical records.
Patient Signature: _____ **Date**: _____

Financial Policy

An insurance policy is an agreement between you and your insurance company. Payment for services rendered and reimbursement from the insurer is ultimately the responsibility of the patient. If your insurance company requires a referral, it is your responsibility to obtain the necessary referrals for each visit. If we do not participate in your plan, payment is expected when services are rendered. Copays, deductibles, and charges for non-covered services are due at time of visit. Interest may be added to past due accounts in the amount of 1.5% monthly. If your account is sent out for collection, you will be responsible for any additional collection costs and attorney fees that may be incurred, including past due interest charges and a late payment service charge.
Patient Signature: _____ **Date**: _____

Medicare & Commercial Insurance Assignment of Benefits

I request that payment of authorize Medicare/Commercial benefits be made directly to me or on my behalf of Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery for any services or products furnished me by him. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits, or the benefits payable for related services.
Patient's Signature: _____ **Date:** _____