80 Maiden Lane, Suite 703, New York, N.Y. 10038 T: 212.385.2400 F: 212.385.2434 TF: 888.NYC.FOOT

PATIENT INFORMATION

Date _____/_____/___

Patient_______________________________________

Address_______________________________________

____

Phone Numbers:

Home__________________ Work_____________

Other__________________ ext________

Age_________ Birth Date_____/_____/___

Sex: ☐Male ☐Female

☐Single ☐Married ☐Widowed ☐Seperated

☐Divorced

Social Security #___________________________

Occupation__________________________________

Employer____________________________________

Employer Phone ___________________________

Employer Address__________________________

____

Spouse Name________________________________

Whom can we thank for referring you?

____

IN CASE OF EMERGENCY CONTACT:

Name_______________________________________

Relationship________________________________

Phone _____________________________________

____

PODIATRIC HISTORY

Have you seen a podiatrist before? ☐ Yes ☐ No

If yes please list:__________________________

Athletic Activities (please indicate frequency)

____
____
____
____
____
____
____
____

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

☐ Ankle Pain	☐ Ingrown toenails	☐ Amputation
☐ Arthritis	☐ Black toenails	☐ Plantar Warts
☐ Athlete's Foot (itchy feet)	☐ Fungal Toenails	☐ Swollen Feet (or ankles)
☐ Bunions	☐ Fractures (broken bones)	☐ Diabetes
☐ Corns, Callouses	☐ Foot surgery	☐ Numbness
☐ Flat Feet	☐ Orthotics	☐ Ulcers
☐ Heel Pain	☐ Melanoma	☐ Cysts
☐ Hammertoes	☐ Neuromas	☐ Other _____
		_____________
		_____________

INSURANCE

Who is responsible for this account?_________________

____

Relationship to Patient___________________________

____

Inusurance Company ______________________________

____

Group # ________________________________

Is Patient covered by additional insurance

☐Yes ☐No

Subscriber Name (if yes) _________________________

____

Birth Date ____-____-____

Social Security # ______-______-______

Relationship to Patient___________________________

____

Insurance Company_______________________________

____

Group#_________________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with ________________________and assign directly to **NYC FOOTCARE,** LLC (Dr. Oliver Zong, Dr. Tina Tsentserensky) 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. If insurance payment is made to me directly for services rendered by the doctors of **NYC FOOTCARE,** LLC, I agree to pay **NYC FOOTCARE,** LLC the amount of the insurance payment. I hereby authorize **NYC FOOTCARE,** LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance benefits. I authorize the use of this signature to all insurance submissions.

____

Repsponsible Party Signature

____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **NYC FOOTCARE,** LLC (Dr. Oliver Zong, Dr. Dina Tsentserensky) for any services famished me by the physicians of **NYC FOOTCARE,** LLC I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance " is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information ro the insurer or agency shown. In Medicare carrier as the full charge , and the patient is responsible only for the deductible are based upon the charge determination of the Medicare carrier.

____

Beneficiary Signature

____

Date

WHAT CAN WE DO FOR YOU TODAY?

Please describe your cheif complaint (include foot, ankle, and hip complaints) and when it started.

____
____
____
____