PATIENT REGISTRATION INFORMATION

Patient #:________________

PLEASE PRINT

TODAY'S DATE: ___/___/______

E-MAIL ADDRESS: ______________________________

LAST NAME: ______________________

FIRST NAME: ______________________ MI ______

ADDRESS: ______________________ APT#______

CITY ______________ STATE ______ ZIP ______

DATE OF BIRTH: ___/___/______

SOCIAL SECURITY#: _____-___-______ GENDER ______

HOME PHONE: (_____) _____-_______

CELL PHONE: (_____) _____-_______

EMPLOYMENT, PRIMARYCARE PHYSICIAN, AND PHARMACY INFORMATION

EMPLOYER: ______________________

OCCUPATION: ______________________

ADDRESS: ______________________

WORK PHONE: (_____) _____-_______ Ext. _______

WHO REFERRED YOU TO US? ______________________________

PRIMARY CARE PHYSICIAN: Last Name: ______________________ First Name: ______________________

ADDRESS: ______________________ PHONE #: (_____) _____-_______ FAX # (_____) _____-_______

______________________ DATE OF LAST VISIT WITH YOUR PCP: ___/___/______

*Providing **Pharmacy Information** will allow us to email the prescription directly to your pharmacy*

PHARMACY NAME: ______________________ PHONE: (_____) _____-_______

ADDRESS: ______________________ CITY ______________ STATE _____ ZIP ______

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: ______________________________

POLICY NO: ______________________

GROUP NO: ______________________

ADDRESS: ______________________ CITY ______________ STATE _____ ZIP ______

PHONE: (_____) _____-_______

SUBSCRIBER (*IF OTHER THAN PATIENT*)

LAST NAME: ______________________

FIRST NAME: ______________________ MI: ______

ADDRESS: ______________________

CITY ______________ STATE _____ ZIP ______

PHONE: (_____) _____-_______

EMPLOYER: ______________________

BIRTHDATE: ___/___/______

RELATIONSHIP TO PATIENT: ______________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: ______________________________

POLICY NO: ______________________

GROUP NO: ______________________

ADDRESS: ______________________

CITY ______________ STATE _____ ZIP ______

PHONE: (_____) _____-_______

EMPLOYER: ______________________

BIRTHDATE: ___/___/______

RELATIONSHIP TO PATIENT: ______________________

WHAT IS THE CHIEF COMPLAINT? ______________________________

ARE THERE ANY OTHER FOOT OR LEG PROBLEMS? ______________________________

FORMER PODIATRIST: ______________________________ **LAST VISIT DATE:** ___/___/_____

How is your general health? ☐ Good ☐ Fair ☐ Poor

Are you now or have you ever been under a physician's care during the past two years for any reason? ☐ Yes ☐ No

If YES, for what reason? ______________________________

Are you taking any medications at the present time? ☐ Yes ☐ No

If YES, what medication and what dosage? ______________________________

Are you allergic or sensitive to: (Please describe your reaction to allergy that you've checked.)

☐ Novocain ☐ Codeine ☐ Cortisone ☐ Sulfa
☐ Aspirin ☐ Penicillin ☐ Adhesive Tape ☐ Other: ______________

Do you have or have you ever had any of the following?

☐ AIDS/HIV	☐ Cancer	☐ Heart Trouble	☐ Prolonged Bleeding
☐ Anemia	☐ Cramps or numbness (in foot or legs)	☐ Hepatitis	☐ Raynaud's Disease
☐ Arthritis/Osteoarthritis	☐ Dermatologic Condition (Skin)	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis, Rheumatoid	☐ Diabetes	☐ High Cholesterol	☐ Thyroid Condition
☐ Asthma	☐ Epilepsy	☐ IBS	☐ Tuberculosis
☐ Back Problems	☐ Eye Problems	☐ Kidney Trouble	☐ Stomach Ulcer
☐ Blood Disease	☐ Gout	☐ Liver Trouble	☐ Varicose Veins
☐ Broken Bones (in foot or legs)	☐ Hardening of Arteries	☐ Phlebitis	☐ Venereal Disease

Your HEIGHT: ________ *(inches)* Your WEIGHT: ________ *(pounds)*

Have you ever been hospitalized: ☐ Yes ☐ No If YES, for what reason and how long: ______________

Do you smoke? ☐ Yes ☐ No If so, how many a day? _______

Alcohol consumption: ☐ Light ☐ Moderate ☐ Heavy ☐ None

Have you ever had surgery: ☐ Yes ☐ No If YES, what type of surgeryand what year: ______________

Is there a family history of: (If YES is checked on any, please note person(s) in family.)

DIABETES:	☐ Yes	☐ No --	☐ Mother	☐ Father	☐ Grandfather	☐ Grandmother	☐ Brother	☐ Sister
HEART DISEASE:	☐ Yes	☐ No --	☐ Mother	☐ Father	☐ Grandfather	☐ Grandmother	☐ Brother	☐ Sister
CANCER:	☐ Yes	☐ No --	☐ Mother	☐ Father	☐ Grandfather	☐ Grandmother	☐ Brother	☐ Sister

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- IF YOU PARTICIPATE IN ANY SPORT(S), PLEASE COMPLETE THE FOLLOWING: (ie, exercise, walking, running, etc.)
- SPORT(S): ______________________________
- YEARS OF SPORT(S) PARTICIPATION: ______________________________
- TRAINING PER WEEK: ______________ RECENT 3-5 MONTH INTENSITY: ______________
- TIME OF DAY TRAINING: ______________________________
- SHOES USED: ______________ SURFACES: ______________
- DO YOU WARM-UP WITH FLEXIBILITY EXERCISES? IF SO, FOR HOW LONG: ______________
- INJURY: DESCRIBE INJURY AND DURATION OF INJURY: ______________________________

____

HAVE YOU SOUGHT OTHER MEDICAL ADVICE: ______________________________

PREVIOUS INJURIES: ______________________________

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient # ____________

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read *(or had the opportunity to read, If I so chose)* and understood the notice.

Patient Name: ____________________________________
(Please Print)

Date: ____________

Parent or Authorized Representative ________________________________
(if applicable)

X Signature: ______________________________________

Assignment of Benefits:

I, the undersigned have health insurance. I assign directly to: Kenneth Meisler, DPM; Rocco Sellitto, DPM; Latoya Haskin, DPM; Stephanie Hochman, DPM; Martin Wendelken, DPM; and Karen Silver, DPM, all medical 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. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic to any insurance I have at this point or in the future.

X Signature: ____________________________________ Date: ____________

KENNETH R. MEISLER. D.P.M., PLLC & ASSOCIATES
210 East 86 Street Ste. 402, New York, NY 10028
Phone: (212) 628-4444 Fax: (212) 570-6120

APPOINTMENT CANCELLATION, NO-SHOWS AND RESCHEDULE POLICY

Our practice is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. In order to be respectful of the medical needs of other patients we ask that you kindly adhere to our cancellation policy.

Please call us at (212) 628-4444 twenty-four hours prior to your scheduled appointment to notify us of any changes or cancellations. If you have a 10:00am. Appointment, you must call by 10:00am the day before your appointment. To cancel a Monday appointment, please call our office by 3:00pm the Friday before.

If you cancel or reschedule with less than 24-hours' notice, you will be charged a fee of $50 for the missed appointment.

Ultrasound guided injections frequently require scheduling time with two doctors. The fee for late cancellation of those appointments will be $75.

Please sign below to consent to these terms.

______________________ ______________________
Print Name **Signature**

____
Date

Revised 1/12/2022