

## INSTRUCTIONS

### Patient Registration Information Form

*(Please print this page and follow the directions)*

1. Please print the **Patient Registration Information form** and fill out.  
The Patient Registration Information form is two pages long. PLEASE PRINT NEATLY.
2. Please print and read the **Notice of Privacy Practices form**, you can also read it online.
3. Print out and sign the **Acknowledgement of Receipt of Notice of Privacy Practices form**. It states that you were provided a copy of the Notice of Privacy Practice and read it (or had the opportunity to read it).
4. You must sign at the two large X's on that form. The first is the HIPAA acknowledgement and the second assigns benefits directly to our offices so that your insurance company will pay us directly. It also explains some of the financial arrangements of the office and allows us to use this one signature rather than having you sign at each visit. Please read the entire page and sign at both X's.
5. Please make sure to bring your insurance card with you when you visit the office. We will need to make a copy of it for our records.
6. If your plan requires a referral, please arrange to have one sent to us prior to your visit as referrals cannot be backdated. Please note that it is your responsibility to do this.
7. Please print and complete the **Appointment Cancellation, No-Show and Reschedule Policy form**.
8. Please note that your copay is required at the time of visit.

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?

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

➤ 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: \_\_\_\_\_

## 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

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**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 \$40 for the missed appointment.**

**Ultrasound guided injections frequently require scheduling time with two doctors. Those appointments will have a \$60 fee.**

Please sign below to consent to these terms.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date