ISLAND
FOOT & ANKLE

Bruce McLaughlin, DPM
Edward McLaughlin, DPM
Anthony Ferraro, DPM
John Kannengieser, DPM
Alexandra LaRocca, DPM
Judah Gomberg, DPM
Maria Cifone, DPM

New Patient Form

Date: ___ /___ /_____

Patient Name: _____ _____ ____ Date of Birth: ___ /___ /_____ Age: ___ Sex: M F
Last First MI

Home Address:_____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ -_____ Cell Phone: (____) _____ -_____ Social Security #: _____-_____-_____

Email: _____

Occupation: _____ Referred to practice by: _____

Primary Care Physician: _____ PCP Address: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____ -_____

Pharmacy: _____ Address:_____ City: _____ State: _____ Zip: _____

What specific problem brought you to the office today?

_____

_____

Allergies to food or medication (please add what type of reaction you have, eg: rash, trouble breathing):

□ Penicillin □ Novacaine (local anesthetic) □ Cortisone □ Sulfa Drugs □ Iodine □ NSAIDS (anti-inflammatory) □ Tape
□ Latex □ Opiates (codeine, oxycontin etc.) □ Antibiotics (specify) □ Other_____

Medical Problems (circle all that apply, list any other issues):

Diabetes type I	Bleeding Disorder	Stroke	Hypertension
Diabetes type II, no insulin	Joint replacement	Chronic Bronchitis	Heart Disease
Diabetes type II, insulin	Gout	Emphysema	Mitral Valve Prolapse
Peripheral Neuropathy	Fibromyalgia	HIV +	Other: _____
Chronic Ulcer of Skin	Cancer _____	Heptatitis B / C	_____
Peripheral Vascular Disease	Organ Transplant _____		_____

Other pertinent health history: _____

_____

Family History: _____

Surgical History: _____

Marital Status: _____ Alcohol Use: _____ Smoking: (current or former) _____ ___ pk/day

Current Medications (name, dose, frequency):_____

_____

If Patient is a Minor: Fathers name: _____ Mothers Name: _____

Parental Signature: _____ Print Name: _____ Date: ___ /___ /_____

• 1111 Montauk Highway Ste 100 West Islip, NY 11795 • Tel: (631) 422-4450 • Fax: (631) 422-4451
• 952 Roanoke Avenue Riverhead, NY 11901 • Tel: (631) 727-3592 • Fax: (631) 727-8892
• 207 Broadway Amityville, NY 11701 • Tel: (631) 264-1910 • Fax: (631) 264-1926
• 6144 Route 25A Suite 14 Wading River, NY 11792 • Tel: (631) 707-8771 • Fax: (631) 494-2319
www.IslandFootAndAnkle.com

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Private Insurance Information

Primary

Name of Insurance Company: _____ Company Contact #: _____

Company Address:_____ City: _____ State: _____ Zip: _____

Insured's Name: _____ _____ ____ Date of Birth: ___ /___ /_____
Last First MI

I.D. # _____ Group # _____

Secondary

Name of Insurance Company: _____ Company Contact #: _____

Company Address:_____ City: _____ State: _____ Zip: _____

Insured's Name: _____ _____ ____ Date of Birth: ___ /___ /_____
Last First MI

I.D. # _____ Group # _____

□ I hereby authorize my insurance benefits to be paid directly to the Physician and I am financially responsible for covering the non-covered services. I also authorize the Physician to release any information required to process the claim.

□ I acknowledge that Island Foot & Ankle has informed me prior to my treatment that my insurance may or may not reimburse me for this treatment because it may be considered medically unnecessary. I have carefully read and understand the above.

□ I acknowledge that I will be subject to a $25 fee for any appointment not cancelled or rescheduled outside of 24 hours.

Patient's Signature: _____ **Witness:** _____Date: ___ /___ /_____

If Patient is a Minor: Parental Signature: _____ Print Name: _____ Date: ___ /___ /_____

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Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal health Information. You may not revoke any actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please speak with us. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print name: _____ **Signature**: _____ **Date**: ___ /___ /_____

Consent for release to other Individuals

In addition, I authorize release of my medical information to the following family members and/or doctors:

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

Signature: _____ **Date**: ___ /___ /_____

Consent for Release of Information

I, _____ give my consent for Dr. McLaughlin or Dr. Ferraro or Dr. Kannengieser or Dr. LaRocca or Dr. Gomberg or Dr. Cifone to leave information relating to my scheduled appointment and results on my answering machine or with a family member named above.

Phone #: (____) _____ -_____

Signature: _____ **Date**: ___ /___ /_____