Patient #____________

## NEW PATIENT INFORMATION FORM

Last Name____________ First____________ Middle____________

Street ____________ City________ ST____ Zip________

Home Phone____________ Cell Phone____________

Email____________ Birth Date ____-____-____ Sex M F

Social Security #____-____-____ Marital Status - M S D W

Primary Care Physician____________ Phone ____________

Occupation____________ Employer____________
Street____________ City/ST____________ Zip________
Work Phone ____________

## RESPONSIBLE PARTY (if under age 18)

Name____________ Relation ____________
Address (if different than above) ____________
Phone ____________

**How did you hear about our office?**

Referred by Dr.____________ Insurance Directory______

Friend (Name)____________ Phone Book ______

ZocDoc.com __ RateMDs.com __ Healthgrades.com __ LIFootCare.com __ GreatFootCare.com __

Google __ Yahoo __ Bing __ Other____________

---

**PRIMARY INSURANCE**____________
**Subscriber (if other than self)** ____________ **DOB**________
*Please provide your card to the receptionist so we can make a copy for our records.

**SECONDARY INSURANCE**____________
**Subscriber (if other than self)** ____________ **DOB**________

**EMERGENCY CONTACT**____________ **PHONE**____________

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to **Drs Pedram A. Hendizadeh, Evan A. Vieira, Alison D. Croughan** as agreed upon at the time of treatment for services rendered. I further agree to be responsible for reasonable fees associated with the cost of collection on my account if not paid in full within 60 days of statement. I give permission to be contacted via phone or mail.

**SIGNATURE**____________ **DATE**____________

**FOR OFFICE USE ONLY: INPUT BY**____________ Revised 8/15

www.LIFootCare.com

**Manhasset:** 2110 Northern Blvd., suite 208, Manhasset, NY 11030 **516.883.3333**
**Huntington:** 181 Main St., Suite 207, Huntington, NY 11743 **631.427.3678**
**Roslyn:** 1514 Old Northern Blvd., Roslyn, NY 11576 **516.484.1420**

# Electronic Medical Records Requires Our Office To Obtain The Following Information

Date: ______________ Patient # ______________

Last Name: __________________ First Name: ______________

Email Address: ____________________

## Primary Care Physician Information

Primary Care Physician: _________________ Phone Number: ___________
Last Name, First Name

Address: ____________________ ____________________
Street Town State

## Are You A Smoker?

☐ No (Never Smoked)

☐ Still Smoking
- ☐ Light
- ☐ Heavy

Number of Years: _____
Number of Packs/Day: _____

☐ Quit Smoking
How many years did you smoke? _____
How many packs/day did you smoke? _____

## Race:

☐ Caucasian
☐ Black or African American
☐ Hispanic or Latino
☐ Native American
☐ Other ______________

## Preferred Language:

________________

## Are You Diabetic?

☐ Yes ☐ No

## Allergies:

_____________
_____________
_____________

## Medications:

_________________
_________________
_________________

**Thank You For Choosing Our Office For Your Foot Care Needs.**
**We Appreciate Your Cooperation.**

www.LIFootCare.com

**Manhasset Office:** 2110 Northern Blvd., suite 208, Manhasset, NY 11030
**516.883.3333**
**Huntington Office:** 181 Main St., Suite 207, Huntington, NY 11743
**631.427.3678**
**Roslyn Office:** 1514 Old Northern Blvd., Roslyn, NY 11576
**516.484.1420**

# 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)**

______________________________________

**Signature**

# Medical History Review

Date: ____________

Name: ____________

Patient Signature: ____________

**Huntington:** 181 Main St., Suite 207, Huntington, NY 11743 631.427.3678 | **Roslyn:** 1514 Old Northern Blvd., Roslyn, NY 11576 516.484.1420
**Manhasset:** 2110 Northern Blvd., suite 208, Manhasset, NY 11030 516.883.3333 www.LIFootCare.com

## Medications

☐ **Taking No Medications**

____________
____________
____________
____________
____________
____________

## General Health

☐ Excellent ☐ Fair
☐ Good ☐ Poor

## Allergies to Medications

☐ **No Drug Allergies**
☐ Allergic to Penicillin
☐ Allergic to Sulfa Drugs
☐ ____________
☐ ____________

## Social History

*Alcohol*
☐ None ☐ Light ☐ Heavy

*Tobacco*
☐ None ☐ Light ☐ Heavy
☐ Still Smoking ☐ Quit Smoking

Number of Years: ____________
Number of Packs/day: ____________
Number of Children: ____________

## Bleeding Disorders

☐ **No Problems**
☐ Anemia
☐ Bleeding Problem
☐ *Other:* ____________

## Metabolic Disorder

☐ **No Problems**
☐ Diabetes
☐ Low Blood Sugar
☐ Thyroid
☐ *Other:* ____________

## Neurologic

☐ **No Problems**
☐ Headaches
☐ Seizures
☐ Head Injury
☐ Depression
☐ Dizziness
☐ Stroke: ☐ R ☐ L Side
☐ Numbness
☐ *Other:* ____________

## Eyes

☐ **No Problems**
☐ R ☐ L Impaired Vision
☐ R ☐ L Cataract
☐ Glasses / Contacts
☐ *Other:* ____________

## Ears

☐ **No Problems**
☐ R ☐ L Impaired Hearing
☐ R ☐ L Hearing Aid
☐ R ☐ L Ring or Buzzing
☐ *Other:* ____________

## Nose / Throat

☐ **No Problems**
☐ Bleeding
☐ Persistent Hoarseness
☐ Sinus Problems
☐ Difficult Swallowing
☐ *Other:* ____________

## Lungs

☐ **No Problems**
☐ Asthma
☐ Wheezing
☐ Coughing up Blood
☐ Shortness of Breath
☐ Pain on Breathing
☐ Problem with Anesthesia
☐ *Other:* ____________

## Heart

☐ **No Problems**
☐ Chest Pain
☐ History of Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Leg/Ankle Swelling
☐ Irregular Heart Beat
☐ *Other:* ____________

## Gastro / Intestinal

☐ **No Problems**
☐ Ulcers
☐ Reflux
☐ Constipation
☐ Diarrhea
☐ Nausea/Vomiting
☐ Change in Bowel Habits
☐ *Other:* ____________

## Gynecological

☐ **No Problems**
☐ Currently Pregnant
☐ Menstruation Problems
☐ Excess Bleeding
☐ Abnormal Breast Exam
☐ *Other:* ____________

## Urinary System

☐ **No Problems**
☐ Painful Urination
☐ Bloody Urine
☐ Frequent Urination
☐ Difficult Urination
☐ History of Kidney Stones
☐ *Other:* ____________

## Cancer History

☐ **No Problems**
☐ Lung ☐ Cervix
☐ Liver ☐ Ovarian
☐ Prostate ☐ Uterus
☐ Colon ☐ Bladder
☐ Skin ☐ Breast
☐ Bone ☐ Kidney
☐ *Other:* ____________

## Past Surgeries

| Past Surgeries | Date |
|---|---|
| ☐ **No Past Surgeries Performed** | |
| ☐ Head / Brain Surgery | ______ |
| ☐ Cataract Surgery ☐ R ☐ L | ______ |
| ☐ Neck | ______ |
| ☐ Thyroid | ______ |
| ☐ Heart Surgery | ______ |
| ☐ Lung Surgery | ______ |
| ☐ Breast Surgery | ______ |
| ☐ Gall Bladder Removal | ______ |
| ☐ Stomach / Bowel Surgery | ______ |
| ☐ Kidney Stones | ______ |
| ☐ Appendix Removal | ______ |
| ☐ Prostate Surgery | ______ |
| ☐ Hysterectomy | ______ |
| ☐ Hemorrhoid Surgery | ______ |
| ☐ Vascular Surgery | ______ |
| ☐ *Other:* ____________ | ______ |

## Musculoskeletal Surgeries

| Musculoskeletal Surgeries | Date |
|---|---|
| ☐ **No Past Surgeries Performed** | |
| ☐ Spine Surgery | ______ |
| ☐ Shoulder Surgery ☐ R ☐ L | ______ |
| ☐ Elbow Surgery ☐ R ☐ L | ______ |
| ☐ Wrist / Hand Surgery ☐ R ☐ L | ______ |
| ☐ Hip Surgery ☐ R ☐ L | ______ |
| ☐ Knee Surgery ☐ R ☐ L | ______ |
| ☐ Ankle / Foot Surgery ☐ R ☐ L | ______ |
| ☐ *Other:* ____________ | ______ |

## Family Health History

☐ **No Health Problems**
☐ Anesthesia Complications
☐ Malignant Hyperthermia
☐ *Other:* ____________

My Height: ______ Feet ______ Inches

My Weight: ______ Pounds

My Shoe Size: ____________

My Previous Foot Doctor: ____________

Reviewed by: Dr. ____________

Date Reviewed / Updated: ____________

____________
____________
____________