# PODIATRY SERVICES OF CNY, PC

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Thank you for choosing Podiatry Services of CNY for your care. Did you know we have been providing care in Central New York since 1978? To help make your appointment go smoothly:

- Bring completed History, Insurance, and HIPAA Acknowledgement forms. Bring ID and your insurance cards. Bring your insurance referral if required.
- Avoid dark socks that pill, it makes the exam more difficult.
- If you wear nail polish on your toes, remove it from all of your toes before your appointment if you are seeing us for a nail related problem.

**Injuries:** If you already had imaging like X-Rays, MRI, or CT, please bring them to your appointment. Workers Compensation: You or your attorney must contact our office before your appointment because these appointments need to be pre-authorized.
**Foot Care Patients:** Routine foot care is generally covered by Insurance and Medicare ***ONLY*** when a patient has vascular disease or diabetes with neuropathy. For most patients, you should be prepared to pay for this service at the time of your appointment.
**Children:** Complicated pediatric issues and structural / postural deformities are easier to care for if we have a developmental history from the Pediatrician and a complete history of previous treatment. For less complicated children's problems like warts, ingrown toenails, and sports injuries our regular forms are fine.
**Patients Without Insurance**: Please be prepared to pay for your appointment and any additional treatment at the time services are provided. A $50.00 deposit will be taken prior to your appointment for your initial exam and a fee schedule is available in the office for x-rays or other procedures. This deposit is not refunded if the appointment is not kept.
**Second Opinions:** We are happy to provide an opinion about other Podiatric care or foot and ankle issues, and many of our second opinions have become patients in our practice. For a good opinion, we need as much information as possible, so medical records, operative records, and imaging studies should be brought to your appointment.
**Elective and Corrective Surgery:** We do hundreds of procedures every year at local surgery centers and hospitals. If you were referred for bunion surgery, hammertoe surgery, or other procedures, we will make every effort to accommodate your schedule if you inform us at your appointment.

6647 Kirkville Road
East Syracuse, NY 13057
315 433-0090
fax 315-433-0115

4912 W. Genesee Street
Camillus, NY 13031
315-487-2631
fax 315-487-4893

111 N. Broad Street
Norwich, NY 13815
607-336-3338
fax 607-334-8074

61 Delano Street
Pulaski, NY 13142
315-298-3644
fax 315-298-5061

15 New Street
Oswego, NY 13126
315-342-9743
fax 315-342-9745

171 Grant Avenue
Suite 1
Auburn, NY 13021
315-255-0070
fax 315-255-0073

4623 Onondaga Blvd.
Syracuse, NY 13219
315- 422-1870
fax 315-422-7066

514 South Bay Road
N. Syracuse, NY 13212
315-458-1777
fax 315-458-9661

110 N. Main St.
Cortland, NY 13045
607-756-8831
fax 607-756-8888

208 Tuscarora Road
Chittenango, NY 13037
315-687-9400
fax 315-687-9494

2187 County Route 12
Central Square, NY 13036
315-668-9532
fax 315-668-0164

15 East Genesee Street Suite 260
Baldwinsville, NY 13027
315-635-4619
fax 315-635-4689

| Height ____' _____" | Weight _____ lbs | Shoe Size _____ |
|---|---|---|

**Podiatric History**

| | |
|---|---|
| Tell us your foot / ankle problem? | |
| Have you had this problem before? | ☐ No<br>☐ Yes When? |
| How long have you had it? | |
| Have you had any treatment? | ☐ Yes ☐ No<br>When?<br>How was it treated? |
| Are you having pain? | ☐ Yes<br>☐ No |
| If you are in pain, please rate your pain on this pain scale. | *(circle one number)*<br>(no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst pain)<br>*(mild) (moderate) (severe)* |
| Did you have an injury? | ☐ Yes When?<br>☐ No Were you at work? |
| Have you been to a Podiatrist before? | ☐ Yes For this problem?<br>☐ No For a different problem? |
| Do you have Diabetes? | ☐ Yes<br>☐ No Last Hemoglobin A1C? _____ |
| Do you use any special shoes, shoe inserts, or braces? | ☐ No<br>☐ Yes What? |

Please mark if you have any of the following, or were treated previously:

| | | | |
|---|---|---|---|
| ☐ Ankle Pain<br>☐ Ingrown Toenails<br>☐ Bunions | ☐ Corns / Calluses<br>☐ Athlete's Foot<br>☐ Flat Feet | ☐ Heel Pain<br>☐ Numbness in Feet<br>☐ Onychomycosis | ☐ Swollen Feet<br>☐ Plantar Warts<br>☐ Lesions |

Is there any other information about your problem you would like us to know?

Who may we thank for your referral to our practice?

**Medical History**

*Place a mark to indicate if you currently have or previously had any of the following:*

| | | | |
|---|---|---|---|
| ☐ AIDS / HIV | ☐ Diarrhea | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Anemia | ☐ Diabetes | ☐ Kidney Disease | ☐ Sinus Problems |
| ☐ Angina | ☐ Ear Problems | ☐ Liver Disease | ☐ Stroke |
| ☐ Arthritis | ☐ Epilepsy | ☐ Low Blood Pressure | ☐ Swelling - Foot/Ankle |
| ☐ Artificial Valve / Joint | ☐ Eye Problems | ☐ Neuropathy | ☐ Swollen Neck Glands |
| ☐ Asthma | ☐ Fainting | ☐ Pain Management | ☐ Tuberculosis |
| ☐ Back Problems | ☐ Foot or Leg Cramps | ☐ Psychiatric Care | ☐ Ulcers |
| ☐ Bleeding Disorder | ☐ Gout | ☐ Radiation Therapy | ☐ Varicose Veins |
| ☐ Cancer | ☐ Headaches | ☐ Rash / Dermatitis | ☐ Venereal Disease |
| ☐ Chest Pain | ☐ Heart Disease | ☐ Respiratory Disease | ☐ Weight Loss |
| ☐ Circulation Problems | ☐ Hepatitis | ☐ Rheumatic Fever | ☐ Other _____ |
| ☐ Other _____ | ☐ Other _____ | ☐ Other _____ | |

**Surgeries, Hospitalizations, Major medical events you have had**

| *Procedure or Event* | *Year* | *Procedure or Event* | *Year* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Have you had any anesthesia issues? ☐ Yes ☐ No What? _____

**Medications (if you need more space, please bring a list)**

| *Prescription* | *Dosage* | *Frequency* | *Prescription* | *Dosage* | *Frequency* |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

**Allergies** ☐ ***No Known Allergies***

| *Allergen* | *Reaction* | *Allergen* | *Reaction* |
|---|---|---|---|
| ☐ Local Anesthetic | _____ | ☐ Tapes | _____ |
| ☐ Penicillins | _____ | ☐ Sulfa | _____ |
| ☐ Blood Thinners | _____ | ☐ Latex | _____ |
| ☐ Seafood / Iodine | _____ | ☐ Codeine | _____ |
| ☐ Other | _____ | ☐ Other | _____ |

**Family History**

| *Condition* | *Relative* | *Condition* | *Relative* |
|---|---|---|---|
| ☐ Diabetes | _____ ☐ | ☐ Hypertension | _____ |
| Heart Disease | _____ | ☐ Circulatory Problems | _____ |
| ☐ Bleeding Disorder | _____ | ☐ Other | _____ |

**Social History**

Do you exercise or play a sport? ☐ Yes ☐ No What? _____

Tobacco Use ☐ I have never used tobacco products (under 100 cigarettes in lifetime)
☐ I used tobacco but quit in _____(year).
☐ I currently use tobacco. I smoke _____ cigarettes per day.

Do you drink alcohol? ☐ Yes ☐ No # of drinks per day? _____ per week? _____

Do you consume caffeine (coffee, tea, soda, etc….)? ☐ Yes ☐ No # per day? _____

Do you use recreational drugs? ☐ Marijuana ☐ Cocaine ☐ Other _____How Often?_____

**Review of Systems**

*Constitutional*

☐ Fever ☐Chills ☐ Sweats ☐ Weight Changes

*Head, Eyes, Ears, Nose, Throat*

☐ Wear eyeglasses/contacts ☐ Double Vision ☐ Difficulty Swallowing ☐ Nosebleeds ☐Dentures
☐ Cataracts ☐ Neck Pain ☐ Dizziness ☐ Sore Throat ☐ Ringing in Ears ☐ Vision Problems

*Cardiovascular*

☐ Chest Pain ☐ Edema ☐ Lymphedema ☐ Heart Murmur ☐ Palpitations ☐ Leg Pain/Cramps

*Hematologic*

☐ Bleeding Problem ☐ Anemia ☐ Lymphoma ☐ Swollen Glands ☐ Skin Lump

*Respiratory*

☐ Difficulty Breathing ☐ TB Exposure ☐ Wheezing ☐ Cough ☐ Pulmonary Disease

*Gastrointestinal*

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Decreased Appetite ☐ Abdominal Pain ☐ Constipation

*Endocrine*

☐ Frequent Thirst ☐ Frequent Urination ☐ Thyroid Disease ☐ Kidney Disease ☐ Prostate Problems

*Musculoskeletal*

☐ Weakness ☐ Prior Fractures ☐ Joint Pain ☐ Muscle Pain ☐ Fibromyalgia

*Nervous System*

☐ Ataxia ☐ Neuropathy ☐ Convulsions ☐ Confusion ☐ Headache ☐ Fainting ☐ Speech Problem

*Skin*

☐ Rash ☐ Ulcer ☐ Cracking ☐ Infections ☐ Eczema ☐ Psoriasis ☐ Hair Loss ☐ Color Change

*Immunologic*

☐ Dermatitis ☐ Rheumatoid Arthritis ☐ Collagen Vascular Disease ☐ Seronegative Disease

*Psychiatric*

☐ Nervousness ☐ Anxiety ☐ Depression ☐ Memory Loss ☐ Tension

**Treatment Consent**

***I hereby consent and give my permission to the doctor and the doctor's assistants or designated replacement to administer and perform such procedures upon me as the doctor deems necessary.***

_____ _____

**Patient Signature** **Date**

*If patient is a minor or unable to give consent,*

_____ _____

**Signature of Person Authorized to Consent** **Relationship**

**Patient Information**

First Name _____Last Name _____ Middle Initial _____

Address _____City _____ State _____ Zip _____

DOB ____ / ____ / _____ Social Security # _____ - ____ - _____ Sex ☐ M ☐ F

E-Mail _____ (required, personal or a proxy / relative)

Are you ☐ Single ☐ Married ☐ Divorced / Separated ☐Minor ☐ Widowed

Cell Phone (____) _____ - _____ Home Phone (____) _____ - _____

Name of Employer _____Business Phone (____) _____ - _____

Address _____ City _____ State _____ Zip _____

**Insurance**

**Subscriber**_____ **or ☐ Self Relationship to Patient** _____

**Social Security # _____ - ____ - _____ DOB ____ / ____ / _____**

Insurance Company _____Group # _____

Policy # _____ Effective Date ___ / ___ / _____

*Is the patient covered by additional insurance ? ☐Yes ☐No*

**Subscriber**_____ **or ☐ Self Relationship to Patient** _____

**Social Security # _____ - ____ - _____ DOB ____ / ____ / _____**

Insurance Company _____Group # _____

Policy # _____ Effective Date ___ / ___ / _____

**Emergency Contact / Next of Kin**

*Name* *Relationship* *Phone*

_____ _____ (____) _____ - _____

**Who is your Primary Care Doctor?**

*Name* *Phone* *Last Visit*

_____ (____) _____ - _____ ____ / ____ / _____

**Do you have a preferred pharmacy for prescriptions?**

*Name and Address* *Phone*

_____ (____) _____ - _____

**Podiatry Services of CNY, PC**
**Revision 12/1/2015**

## ACKNOWLEDGMENT 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)

_____ _____

Parent or Authorized Representative (if applicable) Relationship

_____ _____

Signature Date