OKSANA BUTTITA PODIATRY
Foot & Ankle Medicine and Surgery

PODIATRY NEW PATIENT FORM

Today's date: _____

Patient Name:_____ **Referred By**: _____

DOB: _____ **Emergency contact name**: _____ **phone:** _____

Address:_____

Phone number: _____ **Email:** _____

I would like to be reminded about my future appointments via: TEXT / VOICE (please circle one)

Primary doctor:_____ **Last Visit (date) :**_____

Your height: _____ **Your weight**: _____ **Your shoe size**:_____

Why are you here today? (include date of injury if applicable)

_____

What medications are you allergic to?_____

What type of reaction did you experience?_____

What medications are you taking?_____

_____

_____

Please list all your medical conditions?_____

_____

_____

_____

What surgeries have you had in the past?_____

_____

_____

What serious conditions do your parents/siblings/children have? (e.g diabetes, cancer, high blood pressure, heart disease)_____

Do you smoke? Yes / No How many packs per day? ___ How many years?_____

Did you smoke in the past? Yes / No

Amount of alcohol you drink every week?_____

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Health review: Please circle anything that applies to you

General: Fever – Chills – Weakness - Weight gain – Weight loss

Skin: Itching – Rash – Sores – Lumps – Ulcer – Moles

HEAD: Trauma – Headaches

EYES: Glasses – Blurred vision – Vision loss – Cataracts – Glaucoma

EARS: Hearing loss – Vertigo – Earache

NOSE: Discharge – Stuffiness – Itching

MOUTH/THROAT/NECK: Sore throat – Swollen neck – Coughing

CARDIAC: Hypertension – Palpitations – Leg swelling – Irregular heart rhythm

RESPIRATORY: Shortness of breath – Cough – Wheezing – Asthma – History of tuberculosis

GASTROINTESTINAL: Nausea –Vomiting – Heartburn – Diarrhea – Constipation – Abdominal pain

URINARY: Frequent nighttime urination – Blood in urine – Pain with urination – Incontinence

VASCULAR: Pain in calves while walking – Pain to legs at rest – Varicose veins – Thrombosis

NEUROLOGIC: Loss of sensation – Numbness to hands/feet – Tremors – Seizures

ENDOCRINE: Thyroid problems – Heat/Cold intolerance – Excessive sweating

PSYCHIATRIC: Anxiety – Depression

OTHER PROBLEMS NOT LISTED ABOVE:_____

FOR PATIENTS WITH DIABETES:

Last HBA1c?_____

Who is your endocrinologist: _____

Are you wearing diabetic shoes: Yes / No ***Date you last received shoes*** _____

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

Patient Signature:_____ Date: _____

I have personally reviewed the above information.

Physician Signature: _____

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AUTHORIZATION FOR TREATMENT

I hereby give my consent for Dr. Oksana Buttita to render medical services, lab, x-rays, etc. I authorize any holder of medical and or other information about me to be released to assist the processing of my medical claim.

_____ _____

Patient name (print) ***Date***

_____

Guardian name (print)

Assignment of Insurance Benefits Treatment / Financial responsibility

I hereby request that my insurance carrier make payments directly to Dr. Oksana Buttita for any and all services rendered by this office. I, the undersigned, understand that Dr. Oksana Buttita will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I also understand that should my insurance company fail to render payment for services received, I am fully responsible for the payment of any and all deductible and / or co-payment amount, and for charges incurred that are not subject to any payment by my insurance company. Should it be necessary for Dr. Oksana Buttita to engage professional collection effort, I will be held responsible for any and all additional cost of collections, including but not limited to agency fee, attorney fees, court costs and interest.

I further understand that if injury results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payments of the fees are not contingent upon settlement of litigation. However, I hereby instruct my attorney to pay the bill in full directly from the proceeds from any settlement or judgment rendered on my behalf

Insurance payments are based on your policy. Upon completion of your service, when your insurance company has paid its portion, the remaining balance will be forwarded to the patient.

Patients will be responsible for the payment of additional charges and any costs associated with collection of patient balances.

(SHOULD YOU HAVE ADDITIONAL INSURANCE PLEASE ADVICE THE OFFICE)

Our billing to your insurance carrier is done as a courtesy to our patient.

I understand the above financial commitment is due to me upon rendering of services.

_____

Signature

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our commitment here at Dr. Oksana Buttita's office is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all protected health information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- *During treatment,* we *may find if necessary to acquire a laboratory analysis.*
- *For payment purposes, we may use the services of a billing agency.*
- *During health care operations, we may need a second opinion.*

We here at Dr. Oksana Buttita's office are committed to comply with all Federal, State and Local Laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual. This written authorization may be revoked at any time by individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to bring this to our attention.

I have read and understood the above Notice of Privacy Practices.

Signature: _____ **Date:**_____

(Patient or legal guardian)