Practice: FABIENNE ROTTENBERG DPM, F.A.C.F.A.S **Today's Date:** ______________

Name: ________________________ **DOB:** ____________ **Chart Number:** ____________

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** ____________

Email Address: ________________________ **Spouse/Partner Name:** ____________

Address: ________________________ **City:** ____________ **State:** ______ **Zip:** ________

Home #: ______________ **Cell #:** ______________ **Other #:** ______________

Employer: ________________________ **Phone:** ____________

Employer Address: ____________________ **City:** ____________ **State:** ________ **Zip:** ________

Primary Insurance: ________________________ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: ______________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: ______________ Sex: ☐Male ☐ Female DOB: ___/___/___

Address: ________________________

Policy ID: ____________ Group ID: ____________ Employer: ____________

Secondary Insurance: ________________________ Are you the insured? ☐ Yes ☐ No

Subscriber Name: ______________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: ______________ Sex: ☐Male ☐ Female DOB: ___/___/___

Address: ________________________

Policy ID: ____________ Group ID: ____________ Employer: ____________

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: ________________________

What is the reason for your visit today? ________________________

____

How long has this bothered you? ____________ ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? ________________________

____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other: ____________

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ________________________ Date: ________________________

DR. FABIENNE ROTTENBERG, D.P.M., F.A.C.F.A.S.

History and Physical

Name:____ D.O.B:_________________ Chart#:__________

Medical History:
☐ Alcoholism ☐ Blood Disorders ☐ Circulation Problems ☐ Musculoskeletal ☐ Breathing Issues
☐ Liver ☐ Sleep Apnea ☐ Gout ☐ Allergies ☐ Heart Disease ☐ Asthma
☐ Heart Murmur ☐ Stomach/Bowel ☐ Depression ☐ Anxiety Disorder ☐ Mental Illness ☐ Kidney Disease
☐ Blood Clot ☐ High Cholestrol ☐ Heart Murmur ☐ High Blood Pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy (*specify*) ______________ ☐ Thyroid disease (*specify*)__________ ☐ Diabetes (☐ type 1, ☐ type 2)
☐ Arthritis (*specify*) __________________ ☐ Other (*specify*) ☐ HIV ☐ CVA
Are You Pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin Disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: ____
Do you have any artificial joints? ☐ Yes (where? ________) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?: ___________
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: ________________________________
☐ No, I have never had a substance abuse problem
What is your occupation? ____
Do you excersize regularly? ☐ No, I do not excersize regularly ☐ Yes, I do the following excersize: ________________________
____

Family History Is there any family history (*blood relative*) of : (*please indicate family member*)
☐ Alzheimer's ___________________________ ☐ Depression ___________________________
☐ Arthritis ___________________________ ☐ Diabetes ___________________________
☐ Bleeding Disorders ___________________________ ☐ Emphysema ___________________________
☐ Blood clot ___________________________ ☐ Heart disease ___________________________
☐ Cancer ___________________________ ☐ High Blood Pressure ___________________________
☐ Cataracts ___________________________ ☐ Neurological ___________________________
☐ Circulation Problems ___________________________ ☐ Strokes ___________________________
☐ Other (*specify*): ___________________________

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular ☐ leg pain when walking ☐ fever ☐ chest pain/pressure ☐ leg swelling ☐ cold hands/feet ☐ fainting ☐ palpalation ☐ vascular disease ☐ valve problems ☐ **NONE**

Genitourinary ☐ blood in urine ☐ hesitancy ☐ incontinence ☐ increased urgency decreased frequency excessive urination ☐ kidney disease ☐ kidney stones ☐ **NONE**

Gastrointestinal ☐ abdominal pain ☐ heartburn ☐ blood in stool ☐ vomiting ☐ ulcers ☐ constipation ☐ diarrhea ☐ trouble swallowing ☐ decrease appetie ☐ increase appetite ☐ **NONE**

Integumentary ☐ athletes foot ☐ nail abnormalities ☐ keloids ☐ itchiness ☐ dry,scaly skin ☐ **NONE**

Hematologic ☐ lower leg ulcers ☐ sickle cell disease ☐ anemia ☐ blood thinners ☐ clotting disorders ☐ **NONE**

Neurological ☐ tingling ☐ weakness ☐ seizures ☐ numbness ☐ headaches ☐ tremors ☐ paralysis ☐ **NONE**

Musculoskeletal ☐ back pain ☐ joint swelling ☐ muscle weakness ☐ muscle pain ☐ neck pain ☐ sciatica ☐ joint stiffness ☐ joint pain ☐ joint instability ☐ arthritis ☐ **NONE**

Respiratory ☐ chest pain ☐ wheezing ☐ COPD ☐ coughing ☐ snoring ☐ shortness of breath ☐ emphysema ☐ **NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notfying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ____ **Date:** ___________________________________

Practice Name: FABIENNE ROTTENBERG DPM, F.A.C.F.A.S. **Today's Date:** ________________

Name: ________________ **Chart # :**__________ **Date of birth:**____________

Race: ________________ ☐I prefer not to answer ☐I do not know

(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: ________________ ☐I prefer not to answer ☐I do not know

Preferred Language: ________________ ☐I prefer not to answer

Pharmacy Name: ________________ **Pharmacy Phone:** ________________

Pharmacy Address: ________________ City, State, Zip: ________________

Primary Care Physician: ________________ **Phone:** ____________ **Date Last Seen:** ____________

Address: ________________

Referring Physician:________________ **Phone:** ____________ **Date Last Seen:** ____________

Address: ________________

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No

May we send mail to the address on file? ☐ Yes ☐ No

May we call the phone number on file? ☐ Yes ☐ No

May we leave voicemail on answering machine? ☐ Yes ☐ No

Will you allow internet based delivery reminders like email? ☐ Yes ☐ No

Who may we leave messages with? ☐ Wife ☐Husband ☐Daughter ☐Son ☐Other:____________

Name(s): ________________

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker

☐ Current Some Day Smoker ☐ I decline to answer

☐ Former Smoker

Vital Signs

Blood Pressure: ________ / ________

Height: ____________ Weight: ____________

Current Medications

☐No Known Medications ☐I take the following medications

Name:	Dose:

Allergies

☐No Known Allergies ☐No Known Drug Allergies

Name:	Reaction:

Please Read and Sign: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the doctors office to retrieve my medication history.

Patient Signature: ________________________ Date: ________________

DR. FABIENNE ROTTENBERG, D.P.M., F.A.C.F.A.S.

Privacy Practices

This notice is to let you know about how he may use your Protected Health information, how we protect it, and your rights regarding your Health Information under HIPAA (Federal Privacy Act).

Protected Health Information includes almost any personal information you give us such as name, address, social security #, health insurance information, as well as the medical information you give us, your medical record, information about your medical status, diagnosis, course of treatment, prescriptions, laboratory or radiology tests, etc. This information is considered private and we safeguard it. We use it as necessary to provide you with medical care, for administrative purposes, and through association with business associates. An example of using your information for your medical care would be sharing information with your primary care doctor, or someone else taking medical care of you. An example of administrative purposes would be making appointments or keeping a telephone call log. Business associates may be laboratories, radioligy facilities; billing services, etc. To protect your Health Information, we require that the business associate safeguard your information.

We may disclose your Health Information to the Food and Drug Administraion (FDA), Public Health in csase of reportable disease, Workers' Compensation, Law Enforcement or specific government functions, *e.g.* if we recieve a subpoena for your record.

Although your record is the physical property of the healthcare practicioner or facility that compiled it, the information belongs to you. Your rights regarding your Health Information under HIPAA are:

- Right to inspect and copy your Personal Health Information
- Right to ammend your Personal Health Information
- Right to request a restriction of your Protected Health Information in crtain uses and disclosures
- Right to revoke your authorization to use or disclose health information except to the extent that action has already been taken
- Right to recieve an accounting of certain disclosures we have made, if any, of your Protected Health information
- Right to obtain a paper copy of this notice
- Right to file a complaint

We are required by law to maintain the Privacy of your Health information, and provide you with notice as to our legal duties and privacy practices. We will not use or disclose your Health Information without your authorization, except s discribed in this notice. We reserve the right to change our practices, and make new provisions for all Protected Health Information we maintain. Should our practices change, we will mail a revised notice to the address you have given us.

If you believe your privacy rights have been violated, you can file a complaint with us, or with the Secretary of the Department of Health and Human Services. If you have any questions or require any additional information regarding out notice of privacy practices, please contact our privacy officer at (212)-724-4456.

Signature of Patient:________________________________ **Date:** __________________

Wittness: ____ **Date:** ______________________