PHONE (914) 682-9440 FAX (914) 682-9441

Michael J. Madden, D.P.M., D.A.B.P.M.

311 North Street
White Plains, NY 10605

New Patient Information Form

NAME: _____ DATE: _____

DATE OF BIRTH: _____SEX: _____

ADDRESS:_____

MARITAL STATUS: _____
HOME PHONE #: _____ CELL #: _____

EMPLOYER **(**if employed**):** _____
OCCUPATION : _____ WORK # : _____

MEDICAL INSURANCE: _____
(Primary) (Secondary)
POLICY OR ID #: _____
POLICY HOLDER NAME: _____
RELATIONSHIP TO YOU: _____
DATE OF BIRTH: _____

EMERGENCY CONTACT

NAME: _____
ADDRESS: _____

PHONE # (H): _____ WORK: _____

PLEASE PRESENT INSURANCE CARD & PHOTO ID TO RECEPTIONIST TO COPY

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

YES NO

____ ___ Lung Disease- Type: _____
____ ___ Kidney Disease: _____
____ ___ Arthritis: _____
____ ___ Diabetes: How long? _____
____ ___ Neurological Disease: _____
____ ___ Migraines: _____
____ ___ Psychiatric Disorder: _____
____ ___ Heart Disease: _____
____ ___ Gastrointestinal Disease: Type: _____

____ ___ High Blood Pressure: # of yrs. _____
____ ___ Head or Spinal Injuries: _____
____ ___ Keloids, scarring

____ ___ Seizures, Convulsions or Fainting:
____ ___ Arterial Disease: _____
____ ___ Stroke: _____
____ ___ HIV/AIDS: _____
____ ___ Women: Pregnant/Nursing: _____
____ ___ Extensive Hospitalization: _____
____ ___ Do You Smoke? : Amount: _____
____ ___ Do You Drink? : Amount: _____
____ ___ Muscle Pain
____ ___ Bursitis
____ ___ Stiffness, back pain
____ ___ Sciatica

Please List all Medications You are currently taking:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

ALLERGIES: (check if yes)

___ Penicillin
___Aspirin
___ Sulfa drugs
___ Lidocaine, "caines"
___Iodine or shellfish
____ Adhesive tape
____Morphine ___codeine
___ any chemicals

FAMILY HISTORY: Please check if anyone in your family has/had any of the following: ___ Cancer ___Heart Condition ___ Diabetes ___ High Blood Pressure ___ Bunions ___ Hammertoes ___ Other General Health Problems

Your Past Podiatric History: PLEASE CHECK ALL THAT APPLY:
None ___ Ingrown Toenail(s) ____ Callouses, corns ____ Foot Surgery ____

Orthotics, special shoes ____ Ankle sprains ____ Warts ___ Foot Pain ____

SURGICAL HISTORY: (Date & Type) :

_____

HEIGHT: _____ WEIGHT: _____ Date Reviewed: _____, _____,____

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Dr. Michael J. Madden

Podiatric Medicine and Surgery
Diplomate American Board Of Podiatric Orthopedics And Medicine
311 North Street
White Plains, NY 10605

NAME OF INSURED_____

I request that as long as I remain a patient of Dr. Michael J. Madden, that payment of authorized insurance benefits be made on my behalf to Dr. Michael J. Madden, for services rendered to me by him.

I also authorize any holder of medical information about me to release to the Health Insurance Company and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY OBTAIN THIS INFORMATION. PLEASE READ CAREFULLY.

The Health Insurance & Accountability Act of 1996 is a federal program requiring all medical records and all other identifiable health information used or disclosed by us in any form be kept confidential. This Act gives the patient new rights to understand and control how your information is used.

- TREATMENT means providing, coordinating, or managing healthcare services.
- PAYMENT means obtaining reimbursement for services, including billing, collection, and verification of coverage.
- HEALTH CARE OPERATIONS include business aspects of running this practice.

Any other uses and disclosures will only be made with your written authorization. You may refuse said authorization, which we are required to honor.

You have the following rights regarding your private health information, which you can exercise by presenting a written request to Dr. Madden:

- The right to request restrictions on disclosures of protected health information, including disclosures to family members, relatives, close personal friends, and any other person you indicate. We are however, not required to agree to a requested restriction. If we do agree, we must abide by it unless the restriction is removed by you in writing.
- The right to reasonable requests to receive protected information from us at alternative locations or by alternative means.
- The right to inspect and copy your protected information.
- The right to amend your protected information.
- The right to an accounting of disclosures made of your protected information.
- The right to a paper copy of this notice upon request.

_____

SIGNATURE OF PATIENT