ATTENTION: PLEASE READ

Dear Patient,

Due to the volume of patients and paperwork, we ask that you PLEASE fill out the attached paperwork RIGHT AWAY and mail, fax or drop it off at:

6272 West Quaker Road, Orchard Park, NY 14127

OR

Fax to (716) 662-1822

This will allow us to have all your information in the computer prior to your visit. This will expedite your waiting time and will put you on a Cancellation list.

The office requires at least 24hr notice of cancellation. If you fail to notify us and are not present at the time of your appointment, there will be a $50.00 charge and you will not be able to re-appoint until payment is received. Emergencies and extenuating circumstances will be taken into account.

Thank You,

Diane

Office Manager

Thank you for choosing our office for your foot care.

You are scheduled on _____ at _____ at the Orchard Park/Lakeshore location with:

Dr. Peter Riznyk, DPM FACFAS _____
Dr. Angela Riznyk, DPM AACFAS _____

Please fill out the questionnaire below so that we may better treat you at this upcoming appointment.

Name_____SS#___-___-____DOB___/___/___M/F
Address_____
City_____State____ZIP_____
Home Phone_____Cell Phone_____
Email_____

Place of Employment_____Occupation_____
Address_____

Marital Status: Married Divorced Widowed Single
Name of Spouse_____

Emergency Contact Name_____
Phone_____Relationship_____

INSURANCE: Specialist Co-Pay:_____
Primary Insurance_____ID#_____Group_____
Address_____
Policy Holder_____DOB___/___/____Relationship_____

Secondary Insurance_____ID#_____Group_____
Address_____
Policy Holder_____DOB___/___/____Relationship_____

PRIMARY DOCTOR:
Name_____Address_____
Phone_____ Date Last Seen_____

OTHER PHYSICIAN:
Please list any other doctors/specialists involved in your healthcare_____
_____

How were you referred to our office?_____
( ) Doctor ( )Patient ( )Friend/Relative ( )Internet ( )Other

MEDICAL HISTORY AND INFORMATION
What is your current foot problem?_____
How long has it been bothering you?_____Has it ever been treated? Y/N
Any previous foot surgeries? Y/N
If yes, by whom and when?_____

PHARMACY:_____Phone:_____
Address:_____

What MEDICATIONS do you take? Please provide NAME, DOSAGE and the REASON.
( ) Please check here if no medications are taken

	Medication	Dosage	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES:_____
( ) No known allergies

SURGICAL HISTORY:
Please list all surgeries and approximate date
1._____
2._____
3._____
4._____
5._____
( ) Please check here if you have had no surgeries

MEDICAL HISTORY:

CONSTITUTIONAL	Y	N	RESPIRATORY	Y	N	NEUROLOGICAL	Y	N	ALLERGIC	Y	N
Fever			Asthma			Stroke			Drug allergies		
Chills			Shortness of breath			Seizures			Seasonal allergies		
Weight loss			Sleep apnea			Headaches					
Weight gain			Lung cancer			Foot/leg numbness					
Lethargy			COPD			Multiple sclerosis					
EYES	**Y**	**N**	**GI**	**Y**	**N**	**PSYCHIATRIC**	**Y**	**N**	**IMMUNOLOGIC**	**Y**	**N**
Glasses/Contacts			Nausea/vomiting			Depression/Anxiety			HIV/AIDS		
Visual changes			Acid reflux			Panic attacks			Immunocompromised		
Glaucoma			Stomach ulcers			Bipolar			Autoimmune disorder		
Cataracts			Hepatitis			Schizophrenia					
Blindness			Diarrhea			ADHD					
EARS/NOSE/THROAT	**Y**	**N**	**GU**	**Y**	**N**	**ENDOCRINE**	**Y**	**N**	**LYMPHATIC**	**Y**	**N**
Deafness			Frequent urination			Diabetes			Lymphedema		
Hearing loss			Prostate disease			Hypothyroid			Foot/leg swelling		
Sinus issues			Kidney stones			Hyperthyroid			Lymph node swelling		
Nose bleeds			Renal insufficiency			Lupus					
Dentures			Dialysis			Heat/cold intolerance					
HEART	**Y**	**N**	**INTEGUMENT**	**Y**	**N**	**MUSCULOSKELETAL**	**Y**	**N**	**HEMATOLOGIC**	**Y**	**N**
Chest pain			Rash			Foot pain			Vein issues		
Heart attack			Psoriasis			Ankle pain			Peripheral vascular disease		
Heart murmur			Eczema			Arthritis			Clotting disorder		
Heart racing/palpitations			Athlete's foot			Swelling of joints			Blood Clot (DVT)		
Irregular heart beat			Fungal nails			Stiffness of joints			Pulmonary embolus (PE)		
High blood pressure			Foot ulcers			Fracture			Raynaud's		
High cholesterol			Warts			History of amputation			Bleeding disorder		
Congestive heart failure			Skin cancer			Ligamentous laxity			Bruises easily		

OTHER:_____

FAMILY HISTORY:

Diagnosis **Relationship** (Mother, Father, Sister,etc)

( )Cancer, type_____ _____
( )Diabetes (type1/type 2) _____
( )Arthritis _____
( )High Blood Pressure _____
( )High Cholesterol _____
( )Stroke _____
( )Heart Disease _____
( )DVT/Clotting Disorder _____
( )Other_____ _____

DO YOU:

Smoke Y/N Quit:_____ Alcohol Y/N Quit:_____ Illicit Drug Use Y/N Quit:____

Patients Height_____ Weight_____ Shoe Size_____

Please feel free to add anything else you feel is necessary for us to treat you:

_____

_____

I hereby authorize payment directly to Dr. Riznyk for the medical and/or surgical benefit from my insurance. I understand the insurance policies are contracts between myself and my insurance and that I am responsible for any and all charges not paid by insurance.

I also realize that as the patient I am responsible to ensure that a valid referral is in place, if needed. And if I fail to do so, I will be financially responsible for any services rendered.

Signature_____Date_____

Parent/Guardian Signature_____Date_____

SUMMARY of Notice of Privacy Practices (One page + your signature)

The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice").

1. **Uses and Disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location and general condition. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, medical research, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes as specified by law.
2. **Other Uses and Disclosures**. Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
3. **Your Health Information Rights**. You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
    a) You may request restrictions on certain uses and disclosures of your information
    b) You may request that you receive your information from us in a certain way
    c) You may inspect and copy your medical records
    d) You may request an amendment to any record you believe is inaccurate
    e) You may request an accounting of disclosures made of your records
4. **Changes to the Notice**. We reserve the right to change the Notice. If we do so, we will post it in our office, [and on our website] and provide a copy upon request.

5. Complaints. You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

For Office Use Only:

- ☐ Signed form received by: _____
- ☐ Acknowledgment refused: _____
  Efforts to obtain: _____
  Reasons for refusal: _____