Bethlehem Foot Care
261 Delaware Avenue
Delmar, New York 12054
Telephone (518) 439-0423

WELCOME TO OUR OFFICE

We are pleased to welcome and thank you for giving us the privilege of caring for your feet.

We are confident that you will be happy with the care we provide. Our goal is to offer excellent care and follow-up attention, so you will have no reservations about referring others that have similar needs such as yours.

As a new patient we want your experience with us to be positive, efficient and informative. Please arrive ten minutes early for your appointment and bring your insurance cards, a photo id, your specialist co-pay, and an updated list of your medications with dosages.

Please complete all the registration and health questionnaire forms before you arrive for your visit and check in with the receptionist upon your arrival.

As a courtesy, we will confirm the appointment with you the day before your arrival in our office. If you need to reschedule, please provide us with 24 hours notice as we do charge for missed appointments.

Please visit our website for New Patient forms and helpful information www.bethlehemfootcare.com.

Our office has a commitment to you and your foot problems. We will be glad to assist you at any time. We look forward to meeting you!

Dr. Jospeh A. Manzi and
The Staff of Bethlehem Footcare

Practice: JOSEPH A. MANZI, DPM **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

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

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

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

Insured Information

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? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ 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:_____

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 notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

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 cholesterol ☐ 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: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

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	☐ palpitations	☐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 appetite	☐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 notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: JOSEPH A. MANZI, DPM **Today's Date:**

Name: _____ **Chart #:** ____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: English ☐Declined to specify

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

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Have you completed any Advanced Directives? ☐Yes ☐No

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 the 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 Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

BETHLEHEM FOOT CARE
Office of Joseph A. Manzi D.P.M.
261 Delaware Avenue
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(518) 439-0423

PATIENT FINANCIAL POLICY

Self-Pay Accounts

This office designate accounts, S**elf-pay**, under the following circumstances: (1) patient is covered by an insurance plan that out our office does not participate in, (2) patient does not have current, valid insurance card on file, (3) patient does not have a valid insurance on file, or (4) patient does not have health insurance coverage.

Payment is due at the Time of Service:

We accept cash, checks and credit cards.
All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment. A $10.00 fee will be attached to the co – payments that are due and not paid at time of service.
Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, you may be asked to reschedule.
If your co-payment is based on a percentage and you do not have a secondary policy, please be prepared to pay this percentage on the date of service.
Patient responsible balances are due when you check in for your appointment.
In the event you need surgery and you do not have health coverage, we must receive a down payment of 50% of the estimated doctor's fees before we will schedule the surgery.

Proof of Insurance:

Please bring your insurance card(s) with you to each appointment.
It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of a third party -auto insurance- instead of your regular health insurance carrier. You are responsible to provide the office with all information required to bill the third party when you check in for your appointment. We reserve the right to bill for completion of additional paperwork that maybe required by a third party. We do not take workers compensation claims. We will bill benefit assigned claims to both the third party and your health insurance carrier for all services provided by our office at the same time only one time. Should either company reimburse you directly, we accept payment from you in full within 10 days of the receipt of payment. It is your responsibility to understand your insurance contract of covered services.
It is your responsibility to notify the office of changes in your health insurance.

Referrals:

If your insurance plan requires a referral from your designated primary care physician, you must provide the office with this referral at the time of check in. If you do not have a valid referral on file at the time of your appointment, we may ask you to reschedule or pay for the visit in full at the time of service. It is your job to understand your insurance.

Our Responsibility to Report Non Compliance:

It is our obligation under many of the insurance contracts to report patients who: fail or refuse to pay co-payments/deductibles at the time of service, or who repeatedly fail to show for appointments.

Divorce and Child Custody Cases:

The parent who brings the child to the office for care is responsible for the payment of co-payments, co-insurance, deductibles and non-covered insurance balances at the time of service. This office does not honor divorce specifics.

Billing, Payments and Refunds:

All Balances are due in full 14 days of the statement date. Repeat billing of balances will have an additional charge of $10.00.

If you cannot pay the balance in full within in 14 days, please contact our office to discuss the payment options.

Custom Orthotics are non-refundable. A deposit of 50% is required before the orthotics are ordered. All casting fees are the responsibility of the patient to pay.

It is your responsibility to notify the office of any changes in address, phone, employment, or insurance coverage.

If you make an overpayment on your account, we will refund only if there is no other outstanding debt on your account. If you frequently come to our office we may place the overpayment as a credit on your account to use against future visits.

We reserve the right to report delinquent accounts (after 90 days) to credit bureaus, assess a **collection fee of 33% of the balance owed**, take other collection action or terminate you as a patient of the practice.

I have read the patient Financial Policy and I agree to abide its terms.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature Date