THE CENTER FOR PODIATRIC CARE
& SPORTS MEDICINE

Dr. Josef J. Geldwert
Dr. Katherine Lai
Dr. Ryan Minara

PATIENT INFORMATION SHEET

Name _____ Birth Date _____ Social Security # _____

Address _____Apt._____ City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____ Cell Phone _____

Email _____ Occupation _____ Employer _____
Please check preferred method of communication: Home Phone__ Work Phone__ Cell Phone__ Email__

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other

Referred By _____ Previous Podiatrist/Phone _____

Primary Care Doctor _____ Phone _____

Primary Insurance: _____ Policy/Grp#: _____
Policy Holder: _____ Date of Birth: _____ SS#: _____
Relationship to Insured: ___Self ___Spouse ___ Child ___ Other

Secondary Insurance: _____ Policy/Grp#: _____
Policy Holder: _____ Date of Birth: _____ SS#: _____
Relationship to Insured: ___Self ___Spouse ___ Child ___ Other

Health Insurance: Please provide your card for scanning purposes.

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Birth Date Of Insured_____

Authorization/Responsibility Agreement

I hereby authorize my insurance company to pay the proceeds of any benefits to the doctors of this office. I understand that I am responsible for any outstanding balance in accordance with my plan and that I will provide proper authorization or referrals for all of my visits that may be required by plan. If I have not provided that which is required by my insurance plan, I agree to pay any outstanding balances directly to this practice. A copy of this can be considered an original for insurance purposes. _____ (Signature)

I understand that the doctor **does not** participate in my insurance plan and therefore I am financially responsible for the medical care received.
_____ (Signature)

Acknowledgement of Receipt of Notice of Privacy Practices
I acknowledge that I may request a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice.

_____ _____ _____ _____

I authorize any holder of medical information concerning me to release to my Insurance carrier or Health Care Financing Administration and its agents any information needed to determine these benefits or benefits of related services.

_____ (Signature) _____ (Date)
Print Name Signature Authorized Representative Date

NAME: _____

MEDICAL INFORMATION

Height _____ Weight _____

Do you have or have you had any of the following (? = Do not know)

	Y	N	?		Y	N	?		Y	N	?
Foot/Leg Injury	☐	☐	☐	High Cholesterol	☐	☐	☐	Hypertension	☐	☐	☐
Foot/Leg Surgery	☐	☐	☐	Diabetes	☐	☐	☐	Blood Disease	☐	☐	☐
Foot/Leg Cramps	☐	☐	☐	Heart Trouble	☐	☐	☐	Hardening of Arteries	☐	☐	☐
Unequal Leg Length	☐	☐	☐	Epilepsy	☐	☐	☐	Circulation Problems	☐	☐	☐
Flat Feet	☐	☐	☐	Liver Disease	☐	☐	☐	Varicose Veins	☐	☐	☐
High Arches	☐	☐	☐	Kidney Disease	☐	☐	☐	Arthritis	☐	☐	☐
Weak Ankles	☐	☐	☐	Toe Nail Problem	☐	☐	☐	Cancer	☐	☐	☐
Bunions	☐	☐	☐	Foot Skin Problem	☐	☐	☐	Asthma	☐	☐	☐
Hammer Toes	☐	☐	☐	Gout	☐	☐	☐	Anemia	☐	☐	☐
Back Pain	☐	☐	☐	Bursitis	☐	☐	☐	Stomach Ulcer	☐	☐	☐
Hip Pain	☐	☐	☐	Wart	☐	☐	☐	Eating Disorder	☐	☐	☐
Knee Pain	☐	☐	☐	Polio	☐	☐	☐	Weight Issues	☐	☐	☐
								Raynaud's/Cold Sensitivity	☐	☐	☐

List any medical conditions not mentioned above, _____

List any previous surgeries. _____

List any allergies to medications, foods or other (please list)

_____

List current medications. _____

Do you now, or have you in the past, smoke? ☐ Yes ☐ No If yes, how often? _____

Do you now, or have you in the past, drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Pharmacy Phone Number** (Important. Please provide what info you have):

Name: _____ Phone #: _____

Zip Code: _____ Address/Cross Streets: _____

Chief reason for visit today: _____

_____

Activities You Participate In:

☐Walking	☐Hiking	☐Pilates	☐Soccer	☐Other _____
☐Running	☐Golf	☐Yoga	☐Volleyball	
☐Triathlon	☐Aerobic Machine	☐Weights	☐Field Hockey	
☐Biking	☐Aerobic Class	☐Basketball	☐Lacrosse	
☐Swimming	☐Dance	☐Football	☐Baseball	

THE CENTER FOR PODIATRIC CARE AND SPORTS MEDICINE

JOSEF J. GELDWERT, DPM, FACFAS
KATHERINE M. LAI, DPM, FACFAS
RYAN MINARA, D.P.M.

I, _____ have requested treatment from Dr. Geldwert, Dr. Lai and/or Dr. Minara. I have read and understand the following:

1. I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.

2. All co-payments must be paid at the time of service. This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e., for injections or x-rays.)

3. I am responsible for obtaining any and all required referrals for service.

4. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.

5. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contact with my insurance carrier.

6. The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.

7. Fees associated with orthotic casting, prepared at my request, are my responsibility. Should I choose stop the process of making the orthotics, I am still responsible for these fees, once the cast as been taken.

8. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office's financial institution. This current rate may be obtained by calling the Billing Manager at 212-996-1900.

_____
Patient Signature/Name

_____
Guardian Signature if applicable

_____
Date Signed

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