BERKSHIRE PODIATRY CENTER, LTD.

CHART NO._____ **DOCTOR**_____

PLEASE PRINT:

FIRST NAME_____ **M.I.**_____ **LAST NAME**_____

DOB_____**(MM/DD/YYYY)** **SEX**_____ **S.S. #**_____-_____-_____

ADDRESS_____ **CITY**_____**STATE**_____**ZIP** _____

MARITAL STATUS_____ **EMPLOYER**_____

OCCUPATION (TYPE OF WORK YOU DO)_____

HOME PHONE_____-_____-_____ **WORK PHONE**_____-_____-_____

CELL PHONE_____-_____-_____ **EMAIL ADDRESS**_____

EMERGENCY CONTACT (FIRST & LAST NAME)_____

EMERGENCY CONTACT PHONE #_____-_____-_____ **RELATIONSHIP TO PATIENT**_____

PRIMARY INSURANCE COMPANY NAME_____

SUBSCRIBER'S NAME_____**SUBSCRIBER'S DOB**_____**(MM/DD/YYYY)**

S.S. #_____-_____-_____ **CONTRACT/ID#**_____ **GROUP #**_____

SECONDARY INSURANCE COMPANY NAME_____

SUBSCRIBER'S NAME_____**SUBSCRIBER'S DOB**_____**(MM/DD/YYYY)**

S.S. #_____-_____-_____ **CONTRACT/ID#**_____**GROUP #**_____

HOW WERE YOU REFERRED? ___**PHYSICIAN** ___**FRIEND** ___**FAMILY MEMBER** ___**SELF**

___**PHONE BOOK** ___**NEWSPAPER** ___**WEBSITE**

PLEASE LIST NAME OF PERSON REFERRING YOU:_____

PRIMARY CARE/FAMILY PHYSICIAN:_____**PHONE #**_____

DATE LAST SEEN BY PRIMARY CARE/FAMILY PHYSICIAN:_____

I hereby certify the above information is correct to the best of my knowledge and give permission to Dr. Schifalaqua/Dr. Weisberg/Dr. Stache to examine and treat my condition. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, or any other health plan, to Berkshire Podiatry Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize release of any medical information concerning my treatment to my insurance company, other doctor's office or attorney.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

FAMILY HISTORY

PATIENT NAME_____

CONDITION	MOTHER	FATHER	SISTER	BROTHER	ONSET DATE
ARTHRITIS					
BUNION					
BACK PROBLEMS					
CARDIAC ARTERY DISEASE					
CONGESTIVE HEART FAILURE					
CHRONIC OBSTRUCTIVE PULONARY DISEASE					
DIABETES					
DIABETIC ULCERS					
FLAT FEET					
GOUT					
HEPATITIS B					
HAMMER TOE(S)					
HYPERTENSION					
PERIPHERAL VASCULAR DISEASE					
STROKE					

_____ _____

PATIENT SIGNATURE DATE

BERKSHIRE PODIATRY CENTER, LTD

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME_____ **DATE OF BIRTH**_____

REASON FOR TODAYS VISIT: _____

_____

HEIGHT: _____ **WEIGHT**: _____ **SHOE SIZE**:_____

SMOKING STATUS: DO YOU OR HAVE YOU EVER SMOKED? _____

IF YES: _____PACKS PER DAY

IF FORMER SMOKER WHEN DID YOU QUIT? _____

ARE YOU DIABETIC?_____

IF YES: WHAT WAS YOUR LAST HBA1C?_____ DATE:_____

WHEN WAS YOUR LAST EYE EXAM?_____

HAVE YOU HAD A COLONOSCOPY IN THE LAST TEN YEARS?

IF YES WHAT WAS THE DATE OF THAT EXAM?_____

FEMALES ONLY

WHAT WAS THE DATE OF YOUR LAST MAMMOGRAM?_____

IF XRAYS ARE NEEDED, IS THERE A CHANCE OF PREGNANCY?_____

I CONSENT TO PHOTOGRAPHS BEING TAKEN FOR MY PLAN OF CARE AND ALSO BEING ADDED AS A PERMANENT PART OF MY MEDICAL RECORD AT BERKSHIRE PODIATRY CENTER, LTD. I ALSO CERTIFY THAT ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT/LEGAL GUARDIAN:_____

DATE:_____

BERKSHIRE PODIATRY CENTER, LTD
PATIENT MEDICAL HISTORY

PATIENT NAME_____ **DATE OF BIRTH**_____

MEDICAL CONDITIONS
(CHECK ALL THAT APPLY)

___Anemia	___Anxiety	___Arthritis
___Asthma	___Back Problem	___Cancer Type:_____
___Congestive Heart Failure	___COPD	___Cholesterol (high)
___Cholesterol (low)	___Dementia	___Depression
___Dermatitis	___Diabetes	___Epilepsy
___GERD	___Glaucoma	___Gout
___Headache	___Hepatitis	___HIV
___Hypertension	___Migraine	___MRSA
___Myocardial Infarct	___Pheumonia	___Renal Stone
___Stroke	___TB	___Thyroid Disease
___Ulcer (GI)		

___OTHER_____

SURGICAL HISTORY
(CHECK ALL THAT APPLY)

___Appendectomy	___Breast Augementation/Reduction	___CABG
___Cataract Extract	___Cesarean Section	___Cholecystectomy
___Colectomy	___Ectopic Pregnancy	___D&C
___Fracture Repair: _____	___Gall Bladder	___Gastric Banding
___Heart Valve	___Hernia Repair	___Hip Surgery/Replacement
___Hysterectomy	___Intestinal Bypass	___Knee Surgery/Replacement
___LASIK	___Mastectomy	___Oophorectomy
___Pace Maker	___Prostatectomy	___Shoulder Surgery/Arthroscopy
___Sinus Surgery	___Spinal Surgery	___Splenectomy
___Thyroidectomy	___Tonsilectomy	___Tubal Ligation

___OTHER_____

I certify that the above medical information is correct to the best of my knowledge

Signature of Patient/Legal Guardian:_____ **Date:**_____

BERKSHIRE PODIATRY CENTER, LTD
PATIENT MEDICAL HISTORY

PATIENT NAME_____ **DATE OF BIRTH**_____

MEDICATIONS

Name of Medication	Mg/Ml/Units	Frequency	Condition

Pharmacy of Choice_____ **Phone #**_____ **Zip Code**_____

ALLERGIES (circle all that apply)

Ace Inhibitors	Adhesive Tape	Amoxicillin
Betadine	Erythromycin	Grass/Pollen
IV DYE/Iodine Containing	Keflex	Latex
Lidocaine/Novocaine/Marcaine	NSAIDS	Penicillin
Salicylates	Shellfish	Sulfa
Tetanus Toxoid	Tetracyclines	**NO KNOWN ALLERGIES**
OTHER:		

I certify that the above medical information is correct to the best of my knowledge

Signature of Patient/Legal Guardian_____ **Date:**_____

BERKSHIRE PODIATRY CENTER, LTD.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY, THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of the notice.

Disclosure of protected health information not needing your authorization:

1. Treatment: To coordinate or manage your health care and any related services.
2. Payment: To obtain payment for health care services provided to you by Berkshire Podiatry Center, Ltd.
3. Healthcare Operations: In order to conduct certain business and operational activities. Examples: Quality assessment, employee training, licensing, etc.
4. Others involved in your health care: A member of your family, relative, close friend or any other person you identify. Only information that directly relates to that person's involvement in your health care.
5. Marketing: To contact you with information about treatment alternatives that may be of interest to you via newsletter or in person.
6. Public Health and Safety
7. Process and Proceedings: In response to a court or administrative order, subpoena, discovery request or other lawful process.
8. Law Enforcement: To a law enforcement official if you are a suspect, fugitive, material witness, crime victim or missing person.
9. In cases of Abuse or Neglect.
10. Food and Drug Administration: Examples: for tracking products, product defects or problems, adverse events, to enable product recalls, to make repairs or replacements or to conduct post marketing surveillance as required.
11. Criminal Activity: If we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
12. U.S. Department of Health & Human Services: In order to verify our compliance with the federal privacy laws.
13. Health Oversight: To an agency for activities authorized by law, such as audits, investigations and inspection.

Uses and Disclosures Based on Your Written Authorization:

Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted by law. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. You revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information as described in this notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we are allowed by law to charge for said copies. You may contact us, using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). All restriction requests must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communications: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

BERKSHIRE PODIATRY CENTER, LTD.
CONTACT PERSON: OFFICE MANAGER
50 BERKSHIRE COURT, WYOMISSING, PA 19610
PHONE: 610-373-4154 FAX: 610-373-8651

Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read it if I so chose) and understood the Notice.

____Patient _____Parent _____Authorized Representative)

Print Name	**Signature**	**Date**

BERKSHIRE PODIATRY CENTER, LTD.

50 BERKSHIRE COURT
WYOMISSING, PA 19610
610-373-4154

DISCLOSURE TO FAMILY/FRIENDS

I do not want Berkshire Podiatry Center, Ltd. to disclose any information concerning my care or treatment to individuals without my express written consent or legal authorization.

I authorize Berkshire Podiatry Center, Ltd. to disclose information related to my care and treatment to the following named individual(s):

_____

_____

_____

_____

The above authorization is subject to the following limitations or restrictions:

_____

_____

_____

_____
Patient Name (Printed)

_____ _____
Signature of Patient (or legal representative) ***DATE***

_____
Witness