

LEONARD S. GERBER & CHRISTOPHER BROMLEY, DPM, PC

F. Gabrielle Summers, DPM * Audra Siegel, DPM * Dany Y Jabbour, DPM
22 Fairmont Avenue * Poughkeepsie, NY 12603

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Apt.# City State Zip

S.S#: _____ - _____ - _____ Sex: **MALE** **FEMALE**

Marital Status: Single Married Divorced Partner Widowed Legally Separated

Student: Full Time Part Time Not

Phone: Home () _____ Work () _____ Cell () _____

Email: _____

Employer: _____ Full Part Unemployed Retired

Employer

Address _____
Street Suite# City State Zip

Emergency Contact:

Name: _____ Relationship: _____

Phone: () _____ Work:() _____ Cell:() _____

Primary Insurance Carrier:

Name of Insurance: _____

Address: _____
Street Apt.# City State Zip

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone: Home () _____ Cell () _____

Sex: **MALE** **FEMALE**

Employer: _____ Employer Phone: () _____

Secondary Insurance:

Name of Insurance: _____

Address: _____
Policy Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone: _____

Sex: **MALE** **FEMALE**

Employer: _____ Employer Phone:() _____

Who is responsible for the bill:

Name: _____ Date of Birth: _____

Address: _____

Relationship to Patient: _____ Phone number: _____

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine?

YES NO

Patient Signature: _____ Date: _____

With whom do you allow us to share your health information if you are unavailable?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

****Answers to these questions are required by your Insurance Company****

****What is your primary language?** _____

****What is your race?:**

Caucasian

African American

Asian

Hispanic

Native American/Alaska Native

Native Hawaiian/ Pacific Islander

How were you referred to our office? _____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC of any change to the above information.

Patient or Guardian Signature: _____ **Date:** _____

**ACKNOWLEDGEMENT 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 if I so choose) and understood the Notice.

Patient Name (Please print)

Date

Patient Signature

Parent or Authorized Representative (if applicable)

Date

Signature

History & Medical Information

1. Primary Care Physician: _____
Phone: () _____ Date of Last Visit: _____
2. Height: _____ Weight: _____
3. Former Foot Doctor & Previous Foot Care: _____
4. Do you have Diabetes? **YES** **NO** Are you insulin dependent: **YES** **NO** Blood Sugar: _____ When: _____

****Social History: NONE**

Smoker: Never Daily Occasional Unknown **Alcohol Use:** Y / N **Caffeine Use:** Y / N **Drug Use:** Y / N
Pregnant: Y / N **Nursing:** Y / N

5. Explain your foot/ankle problem: _____
6. When did pain/discomfort begin? (date): _____
Describe pain discomfort: Burning Numbness Sharp Other: _____
Pain Level: 1 2 3 4 5 6 7 8 9 10 (10 being the worst)
7. What makes pain/discomfort better?: _____
8. What makes pain/discomfort worse?: _____

9. Has condition been treated? **YES** **NO** When and how: _____

10. **Allergies:** **None**

Penicillin Aspirin Shellfish Latex Adhesive Tape Narcotic Agent/Codeine
Local Anesthesia Sulfa Drugs Cortisone Other: _____

11. List all Medications and reason for taking them: **None** ****Please attach complete list with doses and frequency****

Vitamins/Supplements: _____

12. What is your Pharmacy name and address? _____ Phone: _____

13. ****Surgical History:**

Have you had Surgery: **YES** **NO**
Describe: (surgery/date): _____

14. ****Family History:** **NONE**

Diabetes: Y / N Who: _____ **Heart Disease:** Y / N Who: _____ **Bleeding Disorders / N** Who: _____
Mental Illness: Y / N Who: _____ **Stroke:** Y / N Who: _____ **High Blood Pressure:** Y / N Who: _____
Kidney Disease: Y / N Who: _____ **Cancer:** Y / N Who: _____ **Arthritis:** Y / N Who: _____
Other Family History: _____

Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC

**Please note your insurance company requires you to check or circle YES or NO to each box **

Constitutional Symptoms:		Gastrointestinal:	
Chills		Stomach Ulcers	
Sweats		Nausea	
Weight Loss		Vomiting	
Fevers		Diarrhea	
Other:		Constipation	
Head, Eyes, Ears, Nose and Throat:		Heartburn	
Wear: Contacts/Eyeglasses		Blood in Stool	
Glaucoma		Hepatitis	
Double Vision		Acid Reflux	
Dizziness		Other:	
Cataracts		Endocrine:	
Nose Bleeds		Often: Thirsty/Urination	
Ringing in Ears		Hypoglycemia	
Difficulty Swallowing		Kidney Disease	
Other:		Premenopausal symptoms	
Cardiovascular:		Thyroid Disorder: Hyper/Hypo	
Phlebitis		High Cholesterol	
High Blood Pressure		Gout	
Chest Pain/Heart Attack/ Cardiovascular Sx		Musculoskeletal:	
Congestive Heart Failure		Tendonitis / Bursitis	
Heart Murmur		Arthritis	
Palpations		Broken Bones: _____	
Mitral Valve Prolapse		Joint: Pain/Swelling	
Swelling in Legs/Ankles		Other:	
Leg Pain/Cramping		Nervous System:	
Other:		Migraines	
Hematological/Lymphatic (blood):		Seizures	
Prolonged: Healing/Bleeding		Strokes	
Anemia		Ataxia (loss of balance)	
Lump in Groin or behind knee		Numbness: tingling/loss of sensation: Where: _____	
Lymphoma		Neuropathy (loss of sensation)	
Swollen Gland		Other:	
Bruise easily		Skin Conditions:	
HIV/AIDS		Rash	
Respiratory:		Sensitivity to Sun	
Shortness of Breath		Skin Ulcers	
Emphysema		Keloid (scarring)	
Cough		Contact Dermatitis	
Bronchitis		Growth on Skin	
Difficulty Breathing		Recurrent Infections	
Asthma		Cracking of the Skin	
Previous Pulmonary Disease		Eczema/Dermatitis/Psoriasis	
Pneumonia		Genitourinary:	
TB (tuberculosis) exposure/treatment		Urination: Painful/Bloody	
Other:		STD's: _____	
Psychiatric: History of...		Dialysis	
Nervousness		Other:	
Tension		Other:	
Depression		Cancer: Type _____	
Anxiety		Lyme Disease	

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____

Date: _____

**Leonard S Gerber, DPM and Christopher Bromley, DPM, PC
ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT**

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC. This authorization is valid until I notify Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC in writing that it is revoked.

I understand that I am responsible for giving "Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC" the correct insurance information at the time services are rendered. Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 145 days the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a \$10 re-billing fee for the statements sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a fee of \$25 for all returned checks.

I understand that I am responsible for all balance not paid by my insurance carrier, including deductible, co-pay, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and our court costs incurred by this office.

Patient or Patients Guardian or Legal Representative Signature

Date

Name of Patient or Guardian or Legal Representative

Relationship to Patient
