

Raymond G. Cavaliere, DPM
201 East 28th St., Suite 1A
New York, NY 10016
Tel # 212-481-0064

PLEASE FILL FORM OUT COMPLETELY, IF NEEDED USE N/A

Last Name _____ First Name _____

Age _____ Date Of Birth _____ Sex _____ Marital Status _____

Preferred Language _____ Race/Ethnicity _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Home Tel # _____ Work Tel # _____ Cell # _____

Email _____

Employed By: _____ Occupation _____

Emergency Contact

Name _____ Relationship _____ Tel # _____

Pharmacy Info * PRESCRIPTIONS ARE SENT ELECTRONICALLY TO YOUR PHARMACY*

Name _____ Address _____ Tel # _____

Medical Insurance Information

Primary Insurance Carrier _____ ID # _____

Name of Insured _____ DOB of Insured _____

Secondary Insurance Carrier _____ ID # _____

Name of Insured _____ ID # _____

Referred By: _____ Tel # _____

Address of Referring Doctor _____

Primary Care Physician: _____ Tel # _____

Address of Primary Care Physician _____

Past Podiatrist: _____

I hereby authorize Dr. Cavaliere to furnish my information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for any amount not covered by my insurance.

I acknowledge that I was provided or offered a copy of the Notice Of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the Notice.

Signature _____ Date _____

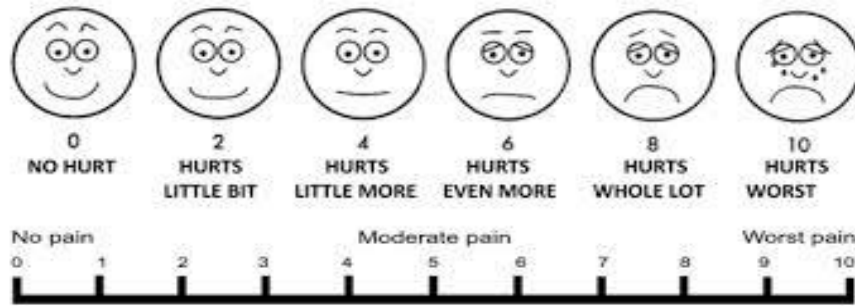
Reason for your visit: _____

Is pain one of the reasons you are here today? Yes No

If yes, where is your pain: _____

How long have you had your pain? _____

How bad is your pain? (Circle below on the pain scale)



Please indicate which foot problems you have or have had in the past:

- | | | | |
|-----------------|--|-----------------------|--|
| Ankle Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heel Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Athlete's Foot | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infection of the foot | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bunions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ingrown Toenails | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Corn & Calluses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Deformity | <input type="checkbox"/> Yes <input type="checkbox"/> No | Plantar Warts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dislocation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Foot | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Foot Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling Ankles/Foot | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Flat Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fracture | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulceration | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Medical History:

- | | | | |
|------------------|--|-------------------|--|
| Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding/Clotting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Seizure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Past Surgical History:

Previous Surgery: Yes No Explain Below:

MEDICATION LIST

Name: _____

D.O.B: _____

Today's Date: _____

Are you on any medications Yes No If yes, list below

Medication Name Medication Dosage(mg)/Directions Medical Condition

Medication Name	Medication Dosage(mg)/Directions	Medical Condition

Have you received a flu vaccine this season? Yes No

Have you received a pneumococcal vaccine? Yes No

Have you fallen in the last 12 months or any fall with injury? Yes No

Allergies: Yes No

Explain:

Social History:

Explain:

Tobacco Yes No

Alcohol Yes No

Substance Abuse Yes No

Family History:

Explain:

High Blood Pressure Yes No

Heart Disease Yes No

Diabetes Yes No

Cancer Yes No

Bleeding/Clotting Yes No

Anesthesia Compli. Yes No

Foot Problems Yes No

Other Yes No

REVIEW OF SYSTEMS:

Do you have any of the following?

CARDIOVASCULAR

ENDOCRINE/METABOLIC

Heart Disease Yes No

Diabetes Yes No

Shortness of Breath Yes No

Thyroid Disorder Yes No

Chest Pain Exertion Yes No

Weight Loss/Gain Yes No

Poor Circulation Yes No

Gout Yes No

Stroke Yes No

Irregular Heart Beat Yes No

High Blood Pressure Yes No

Heart Attack Yes No

Mini-Stroke (TIA) Yes No

Varicose Veins Yes No

Rheumatic Fever Yes No

Pulmonary Embolism Yes No

Blood Clots Leg (DVT) Yes No

GASTROINTESTINAL

- Stomach Ulcers Yes No
- Rectal Bleeding Yes No
- Abdominal Pain Yes No
- Irregularity Yes No
- Colon Polyps Yes No
- Crohn’s Disease Yes No
- Ulcerative Colitis Yes No
- Other: Yes No

HEMATOLOGICAL

- Anemia Yes No
- WBC’s Disorder Yes No
- Platelets Disorder Yes No
- Sickle Cell Yes No

DERMATOLOGICAL

- Skin Rash Yes No
- Keloids/Scarring Yes No
- Hives Yes No
- Discolored Nails Yes No
- Hair Loss Yes No

NEUROLOGY/PSYCHIATRIC

- Headaches Yes No
- Vision Disturbances Yes No
- Depression Yes No
- Mental Illness Yes No
- Seizure Disorder Yes No
- Tremors Yes No
- Sleep Disturbances Yes No
- Inability To Sleep Yes No
- Psychiatric Care Yes No

GENITOURINARY SYSTEM

- Kidney Stones Yes No
- Frequent Bladder Infections Yes No
- Difficulty Emptying Bladder Yes No
- Enlarge Prostate Gland Yes No
- Sexually Transmitted Diseases Yes No

INFECTIOUS DISEASES

- Hepatitis A Yes No
- Hepatitis B Yes No
- Hepatitis C Yes No
- HIV/AIDS Yes No
- Other: Yes No

MUSCULOSKELETAL SYSTEM

- Joint Pain Yes No
- Muscle Aches Yes No
- Bone Loss Yes No
- Previous Fractures Yes No
- Weakness In Limb Yes No
- Osteoarthritis Yes No
- Rheumatoid Arthritis Yes No
- Other: Yes No

RESPIRATORY/PULMONARY SYSTEM

- Asthma Yes No
- Emphysema Yes No
- Bronchitis Yes No
- Tuberculosis Yes No
- Sleep Apnea Yes No

Please list any other medical problems not discussed above:

Patient Signature: _____ **Date:** _____

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NO SHOW/ SAME DAY CANCELLATION POLICY

Thank you for choosing the office of Dr. Raymond G. Cavaliere.
We appreciate your business.

For your appointment, we have set aside the time of physician,
staff and office resources.

If you must reschedule or cancel your appointment, it is your
responsibility to notify us **24 hours in advance**. Please call the
office during business hours, the day before your scheduled
appointment. If you do not, you will be charged a **\$75 NO
SHOW** fee.

Honoring your appointment time allows us to be of service to
other individuals in need of our care.

Please sign and date below.

Thank you for your understanding.

Signature_____ Date_____

PRIVACY INFORMATION PREFERENCES

- Were you offered a copy of the HIPAA Privacy Practice Notice?
(The HIPAA is the last packet on this clipboard) Yes No
- Do you want to be exempt from reporting functions? Yes No
- Can we send mail to address on file? Yes No
- Can we call the phone number on file? Yes No
- Can we leave voicemail on answering machine? Yes No
- Will you allow internet based delivery reminders like email? Yes No
- Do you want electronic access to your patient portal? Yes No
- Who can we leave a message with? Wife Husband Daughter Son
- Other:
-

ADVANCED DIRECTIVES

- Have you completed a Do Not Resuscitate (DNR) order? Yes No
- Have you completed a living will order? Yes No
- Do you have a Durable Power of Attorney? Yes No
- Have you designated a surrogate decision maker? Yes No
- Surrogate Name: _____

Raymond G. Cavaliere, D.P.M

201 East 28th Street, Ste 1A

New York, NY 10016

Tel: (212) 481-0064 Fax: (212) 481-0148

Patient Name: _____

You will be asked for a credit card at the time you check in. The information will be held securely until your insurance have paid their portion and notified us of the amount you share. If your insurance company has assigned a portion that is your responsibility, you will receive a statement from our office. Once you have received this statement, you will have two weeks to mail in payment or contact the office and pay via phone. After two weeks, if payment has not been received, balances will be charged to your credit card and a copy of the charge will be mailed to you.

I authorize Dr. Raymond G. Cavaliere, DPM to charge outstanding balances to my account to the following credit card:

Visa Mastercard Amex Discover
(please circle one)

Account Number: _____

Expiration Date: _____

Security code: _____

Name on card (please print): _____

Signature: _____

Date: _____