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: _____

*****The office of Dr. Raymond G. Cavaliere does not accept Worker's Compensation and No Fault. I hereby confirm that I am not being treated for neither Worker's Comp or No Fault cases.**

Signature _____ Date _____

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	□ Yes □ No	Heel Pain	□ Yes □ No
Athlete's Foot	□ Yes □ No	Infection of the foot	□ Yes □ No
Bunions	□ Yes □ No	Ingrown Toenails	□ Yes □ No
Corn & Calluses	□ Yes □ No	Leg Cramps	□ Yes □ No
Deformity	□ Yes □ No	Plantar Warts	□ Yes □ No
Dislocation	□ Yes □ No	Pain in Foot	□ Yes □ No
Foot Cramps	□ Yes □ No	Swelling Ankles/Foot	□ Yes □ No
Flat Feet	□ Yes □ No	Tired Feet	□ Yes □ No
Fracture	□ Yes □ No	Ulceration	□ Yes □ No

Medical History:

High Blood Pressure	□ Yes □ No	Bleeding/Clotting	□ Yes □ No
Heart Disease	□ Yes □ No	Sleep Apnea	□ Yes □ No
Stroke	□ Yes □ No	Parkinson's	□ Yes □ No
Kidney Disease	□ Yes □ No	Asthma	□ Yes □ No
Lung Disease	□ Yes □ No	HIV/AIDS	□ Yes □ No
Diabetes	□ Yes □ No	Liver Disease	□ Yes □ No
Cancer	□ Yes □ No	Epilepsy/Seizure	□ Yes □ No
High Cholesterol	□ Yes □ No	Hepatitis	□ Yes □ 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

Have you received a COVID-19 vaccine this season? □ Yes □ No

Have you received a flu vaccine this season? □ Yes □ No

Have you received a pneumococcal vaccine? **(Age 65+)** □ Yes □ No

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

Allergies: ☐ Yes ☐ No **Explain Severity:**

_____

_____

Social History: **Explain:**

Tobacco ☐ Yes ☐ No _____

Alcohol ☐ Yes ☐ No _____

Substance Abuse ☐ Yes ☐ No _____

Family History: **Explain: (which relative) ex; Parents, Siblings, Grandparents**

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

High Blood Pressure ☐ Yes ☐ No
Blood Clots Leg (DVT) ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Chest Pain Exertion ☐ Yes ☐ No
Poor Circulation ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Irregular Heartbeat ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
Mini-Stroke (TIA) ☐ Yes ☐ No
Varicose Veins ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No

ENDOCRINE/METABOLIC

Diabetes ☐ Yes ☐ No
Hypothyroidism ☐ Yes ☐ No
Hyperthyroidism ☐ Yes ☐ No
Weight Loss ☐ Yes ☐ No
Weight Gain ☐ Yes ☐ No
Gout ☐ 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
Diverticulitis	☐ 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

HEMATOLOGICAL

Anemia	☐ Yes ☐ No
WBC's Disorder	☐ Yes ☐ No
Platelets Disorder	☐ Yes ☐ No
Sickle Cell	☐ Yes ☐ No

INFECTIOUS DISEASES

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

DERMATOLOGICAL

Skin Rash	☐ Yes ☐ No
Keloids/Scarring	☐ Yes ☐ No
Hives	☐ Yes ☐ No
Discolored Nails	☐ Yes ☐ No
Hair Loss	☐ Yes ☐ No
Eczema	☐ Yes ☐ No
Fungal Nails	☐ Yes ☐ No
Plantar Wart(s)	☐ Yes ☐ No

MUSCULOSKELETAL SYSTEM

Joint Pain	☐ Yes ☐ No
Muscle Aches	☐ Yes ☐ No
Bone Loss (Osteopenia)	☐ Yes ☐ No
Previous Fractures	☐ Yes ☐ No
Weakness in Limb	☐ Yes ☐ No
Osteoarthritis	☐ Yes ☐ No
Rheumatoid Arthritis	☐ Yes ☐ No
Other:	☐ Yes ☐ No

NEUROLOGY/PSYCHIATRIC

Headaches	☐ Yes ☐ No
Vision Disturbances	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Mental Illness	☐ Yes ☐ No
Seizure Disorder	☐ Yes ☐ No
Tremors	☐ Yes ☐ No
Sleep Disturbances	☐ Yes ☐ No
Inability to sleep	☐ Yes ☐ No
Parkinson's Disease	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No

RESPIRATORY/PULMONARY SYSTEM

Asthma	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Pulmonary Embolism	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No
COPD	☐ Yes ☐ No

Please list any other medical problems not discussed above:

_____

_____

Patient Signature: _____ **Date:** _____

PHYSICAL THERAPY POLICY

Physical therapy is **not/ may not be a covered benefit on your insurance policy.**

The cost of physical therapy is as follows:

- **$75** electric muscle stimulation (EMS) & ultrasound (US) per foot, per treatment
- **$85** Laser physical therapy per foot, per treatment

Generally, after surgery or other treatments, EMS/US or Laser physical therapy are required for 12 visits.

After injury, physical therapy is given weekly until pain is resolved and function returns.

These are general guidelines.

Any further questions can be answered during your visit.

Please select the physical therapy option you agree to receive and sign below:

- ☐ $75 per treatment and per foot - Electric muscle stimulation and ultrasound
- ☐ $85 per treatment and per foot – Laser physical therapy

_____ _____

Signature Date

Raymond G. Cavaliere, DPM
201 East 28th St., Suite 1A
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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 **$125 NO SHOW** fee.

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

Thank you for your understanding.

Please sign and date below.

Signature_____ Date_____

PRIVACY INFORMATION PREFERENCES

Were you offered a copy of the HIPPA 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
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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: _____