DANIEL KORMYLO, DPM
754 Route 25A – Suite B
Rocky Point, NY 11778
631-744-8282 Email drkdpm@aol.com

Name: _____ **Date of Birth** _____

Sex: ☐ **M** ☐ **F** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell/Alt:** _____

SS# _____ **E-mail:** _____

Height _____ **Weight** _____ **Blood Pressure:** _____/_____

Pharmacy: _____ **Location/phone** _____

Primary Care Physician: _____ **Phone:** _____ **Date last seen:** _____

Previous Podiatric Physician: _____ **Phone:** _____ **Date last seen:** _____

PRIMARY INSURANCE: _____ **Are you the insured:** ☐ **yes** ☐ **no**

POLICY ID: _____
INSURED INFORMATION:

SUBSCRIBER NAME: _____ **Relationship to insured:** ☐ **spouse** ☐ **child** ☐ **self**

Group ID: _____ **Sex:** ☐ **Male** ☐ **Female** **DOB:** _____

SECONDARY INSURANCE:

INSURANCE NAME: _____ **POLICY ID:** _____

SUBSCRIBER NAME: _____ **Relationship to insured:** ☐ **spouse** ☐ **child** ☐ **self**

Group ID: _____ **Sex** ☐ **Male** ☐ **Female** **DOB:** _____

How did you find out about our practice? _____

Other: _____

What is the reason for your visit today? _____

_____

How long has this bothered you? _____

What treatments have you tried & have they been effective? _____

_____

The pain quality is: ☐ **burning** ☐ **constant** ☐ **dull** ☐ **sharp** ☐ **shooting** ☐ **throbbing**
☐ **tingling** ☐ **other** _____

NAME_____**DATE OF BIRTH** _____

Medical History: ☐ Blood disorders ☐ **Circulation problems** ☐ musculoskeletal ☐ breathing issues

☐ Liver ☐ Sleep apnea ☐ Heart Murmur ☐ High blood pressure ☐ **Heart disease** ☐ Asthma

☐ **Gout** ☐ Depression ☐ Anxiety ☐ Stomach/bowel ☐ Mental Illness ☐ Blood Clot

☐ Kidney ☐ **Diabetes (type 1, type 2)** ☐ Neurological (specify) _____ ☐ Skin disorders

☐ Arthritis (specify) _____ ☐ Thyroid (specify) _____

☐ **other (specify)** _____

_____

Surgical History ☐ Yes ☐ No

Have you ever had any surgical procedures on foot/ankle or anywhere else on you body? ☐ Yes ☐ No
If yes, please describe:

_____

Social History
Do you smoke? ☐ Yes ☐ No ☐ Former Smoker

Family History: ☐ Arthritis Type ☐ Cancer ☐ Flat feet ☐ Bleeding disorders ☐ Circulation problems

☐ Hammer toes ☐ Blood clot/DVT/PE ☐ Diabetes ☐ Heart disease ☐ Bunions ☐ Neurological

☐ Strokes ☐ **Other:** _____

Current Medications: ☐ **None**

I take the following Prescription or over the counter medications:

Name: _____ For: _____ Dose: _____ How often: _____

Name: _____ For: _____ Dose: _____ How often: _____

Name: _____ For: _____ Dose: _____ How often: _____

Name: _____ For: _____ Dose: _____ How often: _____

Name: _____ For: _____ Dose: _____ How often: _____

Name: _____ For: _____ Dose: _____ How often: _____

Allergy ☐ **No Known Allergies** ☐ **Penicillin** ☐ Shellfish ☐ **Sulfa** ☐ Tape ☐ **Latex**

☐ **Iodine** ☐ Aspirin ☐ Tylenol ☐ Ibuprofen ☐ **Codeine** ☐ Other _____

Review of Systems (Please check the box if you currently have any of these symptoms)

Cardiovascular: ☐ Leg pain when walking ☐ chest pressure/angina ☐ High blood pressure/hypertension

☐ leg swelling ☐ cold hands/feet ☐ weight gain/ weight loss ☐ leg cramps ☐ chest pain

Genitourinary: ☐ blood in urine ☐ hesitancy ☐ incontinence ☐ decreased frequency

Gastrointestinal: ☐ kidney disease . ☐ currently pregnant ☐ kidney stones indigestion
☐ blood in stool ☐ vomiting ☐ abdominal pain ☐ heartburn ☐ Ulcers

Integumentary: ☐ athletes foot ☐ nail abnormalities ☐ keloids ☐ itchiness ☐ dry, scaly skin

Hematologic: ☐ lower leg ulcers ☐ bleeding problems ☐ sickle cell disease ☐ use blood thinners
☐ clotting disorders ☐ anemia ☐ rash

Neurological: ☐ seizures ☐ numbness ☐ tingling ☐ weakness

Musculoskeletal: ☐ muscle pain ☐ back pain ☐ neck pain ☐ joint swelling ☐ sciatica
☐ Paralysis ☐ joint pain/stiffness ☐ muscle weakness ☐ joint instability ☐ tremors

Respiratory: ☐ chest pain ☐ coughing ☐ difficulty breathing ☐ snoring ☐ asthma
☐ shortness of breath ☐ wheezing ☐ other _____

FINANCIAL POLICY AND PATIENT RESPONSIBILITY

We are committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policy.

It is the "Patient's Responsibility:

To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-pays. If one is not familiar with your plan coverage, we recommend that the carrier be contacted directly by you.

To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier **PRIOR TO RECEIVING SERVICES.** Any non-covered services are the financial responsibility of the patient.

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

PATIENTS SIGNATURE: _____ DATE: _____

Daniel Kormylo, DPM
Administration
NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2012.

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care generated by Practice Name

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Practice Name. This includes for:

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside Practice Name that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Receipt of Notice of Privacy Practices Form

I, hereby acknowledge receipt of Dr Kormylo's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how Dr Kormylo, DPM may use and disclose my confidential information. I understand that Dr Kormylo, DPM reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Signature _____ **Date** _____

Privacy information Preferences

May we send mail to the address on file? □**Yes** □ **No**
May we call the phone number on file? □**Yes** □ **No**
May we leave a voicemail on answering machine? □**Yes** □ **No**
Will you allow internet based delivery reminders like email? □**Yes** □ **No**
Who may we leave messages with? □ **Wife** □ **Husband** □ **Daughter** □ **Son** □ **Other:** _____