

THE   
CENTER FOR   
PODIATRIC CARE AND  
SPORTS MEDICINE 

JOSEF J. GELDWERT, DPM, FACFAS  
KATHERINE M. LAI, DPM, FACFAS  
RYAN MINARA, D.P.M.

Welcome to our practice. We look forward to helping you with your foot care needs. We have attached our Patient Intake Form for you to complete prior to coming in to our office. You can send the form back to us via fax at 212-996-2110 or email at [east88footcare@aol.com](mailto:east88footcare@aol.com). If neither of those options is convenient, simply bring the completed form in with you at your appointed visit time.

For additional information on our practice, please visit us at [www.healingfeet.com](http://www.healingfeet.com).

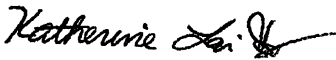
Again, thank you for putting your trust in our practice.

Sincerely,

Dr. Josef J. Geldwert



Dr. Katherine M. Lai



Dr. Ryan Minara



# THE CENTER FOR PODIATRIC CARE & SPORTS MEDICINE

Dr. Josef J. Geldwert  
Dr. Katherine Lai  
Dr. Ryan Minara

## PATIENT INFORMATION SHEET

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status:  single  married  divorced  widowed  other

Referred By \_\_\_\_\_ Previous Podiatrist/Phone \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy/Grp#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to Insured: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other

Seconday Insurance: \_\_\_\_\_ Policy/Grp#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to Insured: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other

Health Insurance: Please provide your card for scanning purposes.

Relationship to Insured:  Self  Spouse  Child  Other Birth Date Of Insured \_\_\_\_\_

### Authorization/Responsibility Agreement

I hereby authorize my insurance company to pay the proceeds of any benefits to the doctors of this office. I understand that I am responsible for any outstanding balance in accordance with my plan and that I will provide proper authorization or referrals for all of my visits that may be required by plan. If I have not provided that which is required by my insurance plan, I agree to pay any outstanding balances directly to this practice. A copy of this can be considered an original for insurance purposes. \_\_\_\_\_ (Signature)

I understand that the doctor does not participate in my insurance plan and therefore I am financially responsible for the medical care received.  
\_\_\_\_\_  
(Signature)

### Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I may request a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice.  
\_\_\_\_\_

I authorize any holder of medical information concerning me to release to my Insurance carrier or Health Care Financing Administration and its agents any information needed to determine these benefits or benefits of related services.

\_\_\_\_\_  
(Signature) \_\_\_\_\_ (Date)

Print Name

Signature

Authorized Representative

Date

NAME: \_\_\_\_\_

**MEDICAL INFORMATION**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you have or have you had any of the following (? = Do not know)

	Y	N	?		Y	N	?		Y	N	?
Foot/Leg Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Leg Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of Arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unequal Leg Length	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flat Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Arches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toe Nail Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bunions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Skin Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hammer Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								Raynaud's/Cold Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List any medical conditions not mentioned above, \_\_\_\_\_

List any previous surgeries. \_\_\_\_\_

List any allergies to medications, foods or other (please list)  
\_\_\_\_\_

List current medications. \_\_\_\_\_

Do you now, or have you in the past, smoke?  Yes  No If yes, how often? \_\_\_\_\_

Do you now, or have you in the past, drink alcohol?  Yes  No If yes, how often? \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Chief reason for visit today: \_\_\_\_\_

**Activities You Participate In:**

- |                                    |  |                                     |                                       |                                      |
|------------------------------------|--|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Walking   | <input type="checkbox"/> Hiking          | <input type="checkbox"/> Pilates    | <input type="checkbox"/> Soccer       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Running   | <input type="checkbox"/> Golf            | <input type="checkbox"/> Yoga       | <input type="checkbox"/> Volleyball   |                                      |
| <input type="checkbox"/> Triathlon | <input type="checkbox"/> Aerobic Machine | <input type="checkbox"/> Weights    | <input type="checkbox"/> Field Hockey |                                      |
| <input type="checkbox"/> Biking    | <input type="checkbox"/> Aerobic Class   | <input type="checkbox"/> Basketball | <input type="checkbox"/> Lacrosse     |                                      |
| <input type="checkbox"/> Swimming  | <input type="checkbox"/> Dance           | <input type="checkbox"/> Football   | <input type="checkbox"/> Baseball     |                                      |

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RYAN MINARA, D.P.M.

I \_\_\_\_\_ have requested treatment from Drs. Geldwert, Lai and/or Minara. I have read and understand the following:

1. I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.
2. All co-payments must be paid at the time of service. This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e., for injections or x-rays.)
3. I am responsible for obtaining any and all required referrals for service.
4. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
5. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
6. The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.
7. Fees associated with orthotic casting, prepared at my request, are my responsibility. Should I choose stop the process of making the orthotics, I am still responsible for these fees, once the cast has been taken.
8. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office's financial institution. This current rate may be obtained by calling the Billing Manager at 212-996-1900.

\_\_\_\_\_  
Patient Signature/Name

\_\_\_\_\_  
Guardian Signature if applicable

\_\_\_\_\_  
Date Signed