Gentle Foot Care Clinic
Rajnish Manohar, D.P.M.

First Name:_____ Last Name:_____

Florida Address:_____

City:_____ State:_____ Zip:_____

Northern Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____

D.O.B.:_____ SS#:_____ Age:_____

Are You Retired? Y N From What State:_____

Employer:_____

Emergency Contact:_____ Phone:_____

Primary Doctor:_____

Primary Doctor Phone #:_____

Reason For Visit:_____

How Did You Hear About Us?_____

I authorize the office of Rajnish Manohar, D.P.M. of Gentle Foot Care Clinic, to leave a message on my answering machine and / or cell phone voicemail that pertains to an appointment, results, and / or a return phone call.

Print Name:_____ Date:_____

Signature:_____

INSURANCE INFORMATION

Primary Insurance:_____ **Secondary Insurance:**_____

Insured Name:_____ **Insured Name:**_____

Insured DOB:_____ **Insured Name:**_____

Insured SS#:_____ **Insured SS#:**_____

Relationship to Patient:_____ **Relationship to Patient:**_____

INSURANCE ASSIGNMENT

I hearby authorize my insurance benefits to be paid directly to Rajnish Manohar, D.P.M. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Patient Signature **Date**

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION- LIFETIME

I certify that the information gien by me in applying for payment under Title XVIII of th Social Security Act is correct, I authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediaries of carriers any information needed for this or a related medicare Claim. I permit a copy of this authorization to be used in place of the original. I repuest that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician serbices to the physician or organization furnishing the services or authorize such physician or organization to submet a claim to Medicare for payment to me.

Patient Signature_____ **Patient Name**_____

Medicare B#_____ **Date**_____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient name above.

/

PATIENT, PARENT, LEGAL GUARDIAN, OR AUTHORIZED REP. **DATE**

Practice's Requirements

The Practice:

- Is required by law to maintain the privacy of your OHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- May be required by State law to maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law. In particular, the Practice is required to comply with the following State statutes: Health General Article, Title 4, Subtitle 3, Confidentiality of Medical Records and Subtitle 4, Personal Medical Records.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Effective Date:

This Notice is in effect as of January 1,2003.

Patient Acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature **Date**

Authorization of Communication

I authorize the office of Rajnish Manohar, D.P.M., of Gentle Footcare Clinic, to contact the named person(s) listed below in the event of an emergency, or if they are unable to reach me:

Name:_____ **Phone#:**_____
Relationship:_____

Name:_____ **Phone#:**_____
Relationship:_____

Name:_____ **Phone#:**_____
Relationship:_____

_____ _____

Patient Signature **Date**

MEDICAL INFORMATION SHEET
Dr. Rajnish Manohar D.P.M.
Gentle Footcare Clinic

List any operations/injuries in the past five years:

_____

_____

List any medications you are currently taking:

_____

_____

Do you smoke? Y/N How long have you smoked?_____ How Much?____

Do you drink alcohol? Y/N How much do you drink per week?_____

Do you have, or have you ever had, any of the following? Check if yes.

__Diabetes	__Rheumatic Fever	__High Blood Pressure
__Asthma	__Gout	__Bleeding Disorders
__Stomach Ulcers	__Epilepsy/Seizures	__Glaucoma
__Circulatory Problems	__Arthritis/Rheumatism	__Kidney Problems
__Anemia	__Cancer	__Heart Problems
__AIDS/HIV	__Stroke	__Hepatitis

Are you allergic to any of the following? Check if yes.

__Aspirin	__Penicillin	__Iodine	__Novacaine
__Codeine	__Sulfa	__Adhesive Tape	__Cortisone

_____other

Patient Name:

Gentle Foot Care Clinic
Rajnish Manohar, D.P.M., P.A.

Note: This form is required to be filled out for each visit you make to our office.

Patient Name:_____**DOB**_____**Date:**_____

Height:_____ **Weight:**_____ **Shoe Size:**_____

Primary Doctor_____

Date Last Seen by Primary Doctor_____

Medications:_____

_____

Allergies_____

Treatment of Foot Pain: If you do not have foot pain please skip to toenail and callus section

Reason for visit:_____

How bad does it hurt from 1 to 10:_____

How long have you had this problem:_____

Where does it hurt the most?_____

Is the pain worse at the beginning of the day or the end of the day?_____

Does it get better or worse with activity?_____

Describe the pain: (circle) Sharp Dull Ache Burn Sting Other:_____

Does the pain radiate or shoot?_____

Is the pain getting worse? (circle) Yes / No

Do you remember hurting the foot/ feet? (circle) Yes / No

If so please describe:_____

For toenail and callus treatment:

Criteria that your insurance company allows are listed below. If you feel that you qualify please check the appropriate box(s).

___Diabetic	___Thick or Deformed Nails	___Ingrown nail(s)
___ On Coumadin	___Painful Nails	___Fungus Nails
___Cramping in legs or feet/circulation problems		___No feeling in feet/toes

Other please list_____