RICHARD C. GALPERIN, D.P.M., P.A.
2909 SOUTH HAMPTON ROAD SUITE F132
DALLAS TX 75224
214-330-9299

NEW PATIENT INFORMATION

PATIENT NAME: ____

ADDRESS: ____

CITY: _______________________________________STATE:________________ ZIP:___________________

PHONE: (___) ___________________________SOCIAL SECURITY NUMBER: _____________________________

CELL: (___) ____________________________***E-MAIL*** (for Portal): ___________________________________

PREFERNCE FOR CONTACT: (Please check all that apply) PHONE CALL __________ TEXT MESSAGE _________ EMAIL _________

DATE OF BIRTH:_____________________ AGE: ___________ MARITAL STATUS: ____________SEX:___________

PATIENTS EMPLOYER:___________________________ PHONE (___)______________________________) _____

ADDRESS: ____

CITY:_______________________________________STATE:________________ ZIP:___________________

SHOE SIZE: ___________ SHOE WIDTH: N M W WEIGHT: _____________ HEIGHT:___________

SPORT/OCCUPATION:_____________________________ USUAL FOOTWEAR: ____________________________

INSURANCE INFORMATION:

(PLEASE CHECK THE INSURANCE CATEGORY THAT APPLIES)

MEDICARE ________ MEDICAID ________ WORKER'S COMP ________ COMMERCIAL INSURANCE ________

1) NAME OF PRIMARY INSURANCE COMPANY:____

I. D. #: ____GROUP #: ___________________________________

NAME/RELATIONSHIP OF INSURED: ________________________________ INSURED'S DATE OF BIRTH:___________

2) NAME OF SECONDARY INSURANCE COMPANY:____

I. D. #: ____GROUP #: ___________________________________

NAME/RELATIONSHIP OF INSURED: ________________________________ INSURED'S DATE OF BIRTH:___________

Please circle your answers to the following required questions for meaningful use according to HIPAA law:

LANGUAGE: English / Spanish ***ETHNICITY: Hispanic or Latino / Non-Hispanic or Latino***

RACE: American Indian or Alaska Native / Asian / Black or African American / Latino or Hispanic / Native Hawaiian / Other Pacific Islander / White

WHO'S YOUR PCP –OR- WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?__________________________

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE RICHARD C. GALPERIN, D.P.M., P.A. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY AND TO MY REFERRING DOCTOR. I UNDERSTAND THAT THE METHOD USED TO TRANSMIT INFORMATION MAY BE BY FACSIMILE, U.S. MAIL AND/OR ELECTRONICALLY GENERATED BY COMPUTER. I HEREBY ASSIGN, TRANSFER AND SET OVER TO RICHARD C. GALPERIN, D.P.M., P.A. ALL OF MY RIGHTS, TITLE AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS UNDER MY INSURANCE POLICY WITH MY INSURANCE COMPANY.

I also consent for my list of current medications to be obtained electronically from my pharmacy [Initials] __________________

Pharmacy name/street/city ____________________________________ ***Phone #*** ____________________________

AUTHORIZING THE PAYMENT OF BENEFITS TO BE MADE DIRECTLY TO RICHARD C. GALPERIN, D.P.M., P.A.:

PATIENT SIGNATURE:____________________________________ ***DATE:*** _______________________

DR RICHARD GALPERIN
A Division of Podiatric Medical Partners of Texas

Patient Name____**Date**__________________

History & Medical Information

Explain your foot/ankle problem(Right) (Left)____

____

Describe the pain/discomfort: (burning) (Sharp) (numbness) Other:________________________

When did the pain/discomfort start?____

What makes the pain/discomfort better?____

What makes the pain/discomfort worse?____

List all medications/herbs/vitamins:____

____

Allergies:____

Surgical History : Have you had surgery? If yes describe below

Type of surgery and Date:____

____

Alcohol Use: (yes) (no)

Tobacco Use: (yes) (no)

Drug Use: (yes) (no)

Caffeine Use: (yes) (no)

Intake Form

General/Constitutional		
Fatigue	O Yes	O No
Fever	O Yes	O No
Overall health	O Yes	O No
Weight gain	O Yes	O No
Cardiovascular		
High blood pressure	O Yes	O No
Endocrine		
Diabetes	O Yes	O No
Genitourinary		
Kidney problems	O Yes	O No
Hematology		
Easy bruising	O Yes	O No
Musculoskeletal		
Arthritis	O Yes	O No
Back problems	O Yes	O No
History of Gout	O Yes	O No
Leg cramps	O Yes	O No
Neurologic		
Balance difficulty	O Yes	O No
Coordination	O Yes	O No
Stroke	O Yes	O No
Peripheral Vascular		
Cold extremities	O Yes	O No
Decreased sensation in extremities	O Yes	O No
Ulceration of feet	O Yes	O No
Podiatric		
Achilles pain	O Yes	O No
Ankle pain	O Yes	O No

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Acknowledgment Of Receipt
Of
Notice Of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Richard C. Galperin, D.P.M., P.A. and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

______________________________________ ____________________
Patient Name (Please print) Date

____
Parent or Authorized Representative (If applicable)

____
Signature

Please list below the following people whom we may release information to in regard to your medical condition

1.____________________________________
2.____________________________________

If your child is a minor please fill out the following:

I hereby authorize Richard C. Galperin D.P.M. to care for the below mentioned minor and to administer therapy as deemed medically necessary or advisable in the diagnosis and treatment of this patient.

____
Patient's Name (Please print)

______________________________________ ____________________
Signature (Parent or Guardian) Date

____
Relationship

______________________________________ ____________________
Witness Date