
**NICHOLAS ARGERAKIS, DPM**
115 East 61st Street, Suite 6A
New York, NY 10065

**DATE:** _____ **CHART #** _____

**NAME:** _____ **DATE OF BIRTH:** _____

**SEX:** _____ **SOCIAL SECURITY#** _____

**HOME ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIPCODE:** _____

**EMAIL:** _____

**HOME PHONE #:** _____ **CELLPHONE #:** _____

**WORK PHONE #:** _____ **OCCUPATION:** _____

**INSURANCE CARRIER:** _____ **ID #** _____

**POLICY HOLDER:** _____ **RELATIONSHIP:** _____ **POLICY HOLDER'S DOB:** _____

**PRIMARY MEDICAL DOCTOR NAME:** _____

**PRIMARY MEDICAL DOCTOR ADDRESS:** _____

**PRIMARY MEDICAL DOCTOR PHONE NUMBER:** _____

**PHARMACY NAME/ADDRESS:** _____

**PHARMACY PHONE NUMBER:** _____

**EMERGENCY CONTACT NAME:** _____ **RELATIONSHIP:** _____

**EMERGENCY CONTACT PHONE NUMBER:** _____

**HOW DO YOU PREFER TO BE CONTACTED?** **EMAIL** **POSTAL MAIL**

**HOW DID YOU HEAR ABOUT OUR PRACTICE?**

| | | | |
|---|---|---|---|
| ❑ | DOCTOR REFERRAL | ❑ | ZOCDOC |
| ❑ | HOSPITAL REFERRAL | ❑ | FRIEND/FAMILY |
| ❑ | INTERNET | ❑ | LOCATION |
| ❑ | INSURANCE PLAN | ❑ | OTHER: |

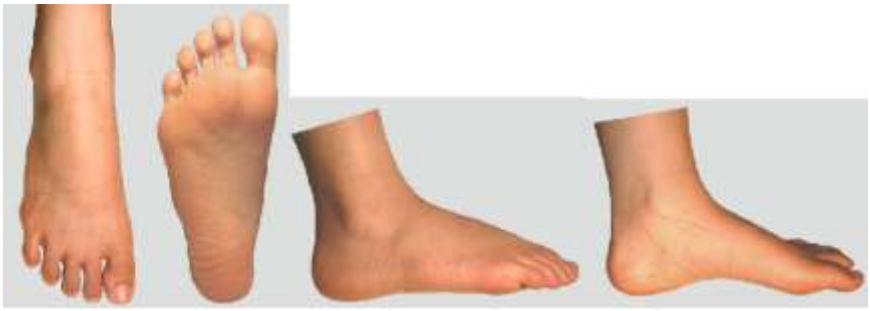
**WHAT COMPLAINT BRINGS YOU TO THE DOCTOR TODAY?**

| | | | |
|---|---|---|---|
| ❑ | BUNIONS | ❑ | INFECTION OR WOUND |
| ❑ | HAMMERTOES | ❑ | PAIN ON BALL OF FOOT |
| ❑ | NAIL DISEASE/FUNGUS | ❑ | ANKLE SPRAIN |
| ❑ | SKIN DISEASE/RASH | ❑ | ORTHOTICS |
| ❑ | DIABETIC FOOT EVALUATION | ❑ | TENDINITIS/MUSCLE PAIN |
| ❑ | RUNNING INJURY | ❑ | FRACTURE/BROKEN BONE |
| ❑ | HEEL PAIN | ❑ | OTHER: |
| ❑ | INGROWN NAIL | ❑ | OTHER: |

PLEASE INDICATE THE LEVEL OF FOOT/ANKLE PAIN YOU ARE HAVING BY CIRCLING A NUMBER

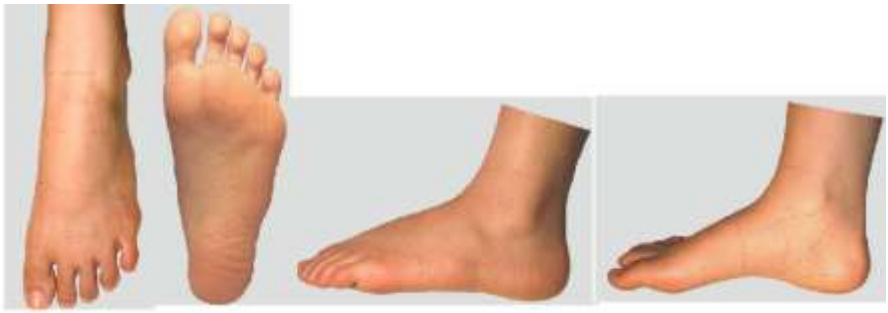

PLEASE CIRCLE THE AREA OF THE FOOT YOU ARE HAVING PAIN OR ARE CONCERNED ABOUT

**RIGHT FOOT**



**TOP** **BOTTOM** **LATERAL/OUTSIDE** **MEDIAL/INSIDE**

**LEFT FOOT**



**HOW LONG HAVE YOU BEEN HAVING THE PROBLEM/PAIN? _____**

**PLEASE DESCRIBE THE NATURE OF THE PAIN:**

❑ SHARP ❑ DULL ❑ ACHING ❑ BURNING ❑ WORSE AFTER ACTIVITY ❑ WORSE IN THE MORNING
❑ WORSE AT END OF THE DAY ❑ TINGLING/NUMBNESS

## PAST MEDICAL HISTORY

| | | | |
|---|---|---|---|
| ❑ | ARTHRITIS | ❑ | CANCER (indicate type): |
| ❑ | BACK PAIN | ❑ | BLEEDING/CLOTTING DISORDERS |
| ❑ | ARTIFICIAL JOINTS | ❑ | BLOOD CLOTS/DVT/PULMONARY EMBOLUS |
| ❑ | GOUT | ❑ | PERIPHERAL VASCULAR DISEASE |
| ❑ | DIABETES | ❑ | HEART DISEASE/HEART ATTACK |
| ❑ | FOOT ULCERS/INFECTION | ❑ | HIGH BLOOD PRESSURE |
| ❑ | NEUROLOGICAL OR NERVE DISORDERS | ❑ | HIGH CHOLESTEROL |
| ❑ | MIGRAINES/HEADACHES | ❑ | HEART MURMUR |
| ❑ | STROKE/TIA | ❑ | KIDNEY PROBLEMS/KIDNEY STONES |
| ❑ | HEPATITIS (circle type): A B C | ❑ | STOMACH ULCERS OR REFLUX (GERD) |
| ❑ | PSYCHIATRIC CARE | ❑ | THYROID ISSUES |
| ❑ | DEPRESSION | ❑ | HIV/AIDS |
| ❑ | ANXIETY DISORDER | ❑ | SUBSTANCE ABUSE |
| ❑ | FIBROMYALGIA | ❑ | OTHER: |
| ❑ | LUNG DISEASE | ❑ | OTHER: |
| ❑ | ASTHMA | ❑ | OTHER: |

## CURRENT MEDICATIONS

| NAME | DOSAGE | FREQUENCY |
|---|---|---|
| ❑ | | |
| ❑ | | |
| ❑ | | |
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| ❑ | | |
| ❑ | | |

**REVIEW OF SYSTEMS**

**ARE YOU CURRENTLY HAVING OR HAVE YOU PREVIOUSLY HAD PROBLEMS WITH YOUR:**
(If yes, please check the appropriate symptoms that apply)

| | | |
|---|---|---|
| CONSTITUTIONAL | NO / YES | ❑ LOSS OF APPETITE<br>❑ GAIN OR LOSS OF WEIGHT<br>❑ FEVER<br>❑ DIFFICULTY SLEEPING<br>❑ CHILLS<br>❑ FEELING WEAK<br>❑ FATIGUE |
| SKIN | NO / YES | ❑ ITCHING<br>❑ RASH<br>❑ HIVES<br>❑ SKIN CANCER<br>❑ SKIN ULCER |
| CHEST/ LUNGS | NO / YES | ❑ CHEST PAIN<br>❑ SWELLING OF THE LEGS<br>❑PALPITATIONS<br>❑ SHORTNESS OF BREATH<br>❑ HEART ATTACK<br>❑ DIFFICULTY BREATHING<br>❑ SLEEP APNEA |
| MUSCULOSKELETAL | NO / YES | ❑ JOINT PAIN<br>❑ NECK PAIN<br>❑ BACK PAIN<br>❑ AMBULATORY DIFFICULTIES<br>❑ MUSCLE PAIN<br>❑ JOINT STIFFNESS<br>❑ SWELLING |
| NEUROLOGICAL | NO / YES | ❑ FAINTING<br>❑ DIZZINESS<br>❑ MOTOR WEAKNESS<br>❑ CHANGE IN MOODS<br>❑ SEIZURE<br>❑ ATAXIA<br>❑ TINGLING/ BURNING<br>❑ MEMORY LOSS<br>❑ CHANGE IN SPEECH |
| HEME/ LYMPH | NO / YES | ❑ ANEMIA<br>❑ BRUISE EASILY<br>❑ BLEEDING<br>❑ SWELLING |

**PLEASE CHECK OR LIST ANY ALLERGIES IN THE APPROPRIATE BOX BELOW**

| | |
|---|---|
| ❑ PENICILLIN | ❑ LATEX |
| ❑ CODEINE | ❑ SHELLFISH |
| ❑ ASPIRIN | ❑ METALS (STEEL, NICKEL) |
| ❑ NSAIDS (ADVIL, MOTRIN, IBUPROFEN) | ❑ TAPE ON SKIN |
| ❑ IODINE | ❑ SEASONAL ALLERGIES |
| ❑ SULFA DRUGS | ❑ OTHER: |

**SOCIAL HISTORY**

| | |
|---|---|
| DO YOU CURRENTLY SMOKE TOBACCO CIGARETTES? | ❑ YES ❑ NO |
| DO YOU CURRENTLY USE ANY ILLICIT DRUGS? | ❑ YES ❑ NO |
| DO YOU CURRENTLY DRINK ALCOHOL EXCESSIVELY? | ❑ YES ❑ NO |
| HAVE YOU EVER BEEN IN A DRUG OR ALCOHOL REHAB PROGRAM? | ❑ YES ❑ NO |

**SURGICAL HISTORY (IF YES, LIST TYPE OF SURGERY)**

| | |
|---|---|
| ❑ FOOT SURGERY | ❑ CANCER SURGERY (list type) |
| ❑ KNEE SURGERY | ❑ CIRCULATION SURGERY |
| ❑ HIP SURGERY | ❑ BRAIN SURGERY |
| ❑ BACK SURGERY | ❑ ABDOMINAL SURGERY |
| ❑ HEART SURGERY | ❑ OTHER: |

**FAMILY HISTORY**

| | |
|---|---|
| DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF DIABETES? | ❑ YES ❑ NO |
| DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF HEART DISEASE? | ❑ YES ❑ NO |
| DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF BLOOD CLOTS? | ❑ YES ❑ NO |

**PATIENT ATTESTATION**

**I HEREBY ATTEST THAT THE INFORMATION PROVIDED IN THE REGISTRATION FORM AND MEDICAL HISTORY IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

| | |
|---|---|
| **PATIENT SIGNATURE:** | **DATE:** |

# Dr. Nicholas Argerakis, DPM

Health Information- HIPPA

I hereby consent and authorize Nicholas Argerakis, DPM to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, by and to its workforces members, health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Nicholas Argerakis, DPM.

I understand that, for example, my health information may be used or disclosed by Nicholas Argerakis, DPM: provide for my care and treatment, including the filling and supplying of prescriptions; communicate among various health care professionals who are involved in my care or treatment; obtain payment for care and treatment provided by Nicholas Argerakis, DPM; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations.

I have read and understand Nicholas Argerakis, DPM's HIPPA Notice of Privacy Practices, which is available in the office and contains information on the uses and disclosures of my protected health information. I understand that Nicholas Argerakis, DPM has the right to change its HIPPA Notice of Privacy Practices from time to time and that whenever an important change is made, Nicholas Argerakis, DPM will post a new notice in the office. I may contact Nicholas Argerakis, DPM at any time to obtain a current copy of the HIPPA Notice of Privacy Practices.

I agree that Nicholas Argerakis, DPM may disclose my protected health information to a family member, close personal friend, or other caregiver, who is involved with my healthcare, and/or payment relating to my healthcare. In that case, Nicholas Argerakis, DPM will disclose only information that is directly relevant to the person's involvement with my healthcare and/or payment relating to my healthcare unless I request otherwise. I agree that Nicholas Argerakis, DPM may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist Nicholas Argerakis, DPM in carrying out its business and healthcare operations including, but not limited to, appointment reminders, insurance items, any clinical care matters and laboratory results. Nicholas Argerakis, DPM may also mail such information my home or other designated locations.

Patient Name_____

Patient Signature_____ Date_____

**Dr. Nicholas Argerakis, DPM**

## Financial Policy

I authorize Nicholas Argerakis, DPM. ("Nicholas Argerakis") to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, and to any other insurance or managed care company covering me or my dependents or insurance beneficiaries, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare, insurance or managed care benefits for services rendered to me (my dependents or insurance beneficiaries, as applicable), be made directly to Nicholas Argerakis, DPM. If my insurance plan will not assign benefits to Nicholas Argerakis, DPM, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan. I understand that I am responsible for all deductible, co-payment and co-insurance amounts and for all non-covered services. I further understand and agree that if my insurance plan sends payment to me rather than Nicholas Argerakis, DPM, I will immediately endorse the check to Nicholas Argerakis, DPM and forward it to Nicholas Argerakis, DPM to be cashed and applied to my account.

Patient Name_____

Patient Signature_____ Date_____