

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 #:				
WORK PHONE #:	OCCUPATION:			
	ID #			
	ATIONSHIP: POLICY HOLDER'S DOB:			
	SS:			
	NUMBER:			
	IVOWIDER			
EMERGENCY CONTACT NAME: RELATIONSHIP:				
EMERGENCY CONTACT PHONE NUMI	BER:			
HOW DO YOU PREFER TO BE CONTAC	CTED? EMAIL POSTAL MAIL			
пои	AV DUD VOLULIE A D. A DOLUT OLUD DD A CTICE?			
HOV	V 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**





Hurts Even More



Hurts Whole Lot

Hurts Worst

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

RIGHT FOOT

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		CANCE	R (indicate type	:):	
	BACK PAIN		BLEEDI	NG/CLOTTING	DISO	RDERS
	ARTIFICIAL JOINTS		BLOOD CLOTS/DVT/PULMONARY EMBOLUS			
	GOUT		PERIPH	ERAL VASCUL	AR DI	ISEASE
	DIABETES		HEART	DISEASE/HEA	RT AT	TACK
	FOOT ULCERS/INFECTION		HIGH BLOOD PRESSURE			
	NEUROLOGICAL OR NERVE DISORDERS		HIGH CHOLESTEROL			
	MIGRAINES/HEADACHES		HEART	MURMUR		
	STROKE/TIA		KIDNEY	PROBLEMS/K	IDNE	Y STONES
	HEPATITIS (circle type): A B C		STOMA	CH ULCERS O	R REFI	LUX (GERD)
	PSYCHIATRIC CARE		THYRO	ID ISSUES		
	DEPRESSION		HIV/AIDS			
	ANXIETY DISORDER		SUBSTANCE ABUSE			
	FIBROMYALGIA		OTHER:			
	LUNG DISEASE		OTHER:			
	ASTHMA		OTHER:			
N	CURRENT MEI	DICATION	<u>IS</u>	DOSAGE	FR	EQUENCY
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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 GAIN OR LOSS OF WEIGHT FEVER GAIN OR LOSS OF WEIGHT GAIN OR LOSS GAIN OR LOSS OF WEIGHT GAN			DI OCCOR A PRETITE
GERELING GERELI	CONTOURNE TENON I A I	NO (NEC	LOSS OF APPETITE
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□ BLEEDING			□ ANEMIA
	HEME/ LYMPH	NO / YES	☐ BRUISE EASILY
□ SWELLING			□ BLEEDING
			□ SWELLING

PLEASE CHECK OR LIST ANY ALLERGIES IN THE APPROPRIATE BOX BELOW

PENICILLIN	LATEX		
CODEINE	SHELLFISH		
ASPIRIN	METALS (STEEL, N	NICKEL)	
NSAIDS (ADVIL, MOTRIN, IBUPROFEN)	TAPE ON SKIN		
IODINE	SEASONAL ALLEI	RGIES	
SULFA DRUGS	OTHER:		
SOC	CIAL HISTORY		
DO YOU CURRENTLY SMOKE TOBACCO CIGARETTI	□ YES □ NO		
DO YOU CURRENTLY USE ANY ILLICIT DRUGS?	□ YES □ NO		
DO YOU CURRENTLY DRINK ALCOHOL EXCESSIVE	☐ YES ☐ NO		
HAVE YOU EVER BEEN IN A DRUG OR ALCOHOL RI	EHAB PROGRAM?	☐ YES ☐ NO	
	(IF YES, LIST TYPE OF SURGE) CANCER SURGER		
FOOT SURGERY	· • • • • • • • • • • • • • • • • • • •		
HIP SURGERY	CIRCULATION SURGERY RRAIN CHROEPLY		
BACK SURGERY	BRAIN SURGERY ABDOMINAL SURGERY		
HEART SURGERY	OTHER:	OLKI	
	MILY HISTORY		
	WIET THOTOKI		
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY	☐ YES ☐ NO		
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY	☐ YES ☐ NO		
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY	☐ YES ☐ NO		
PATIEN I HEREBY ATTEST THAT THE INFORMATION PROV HISTORY IS TRUE, ACCURATE, AND COMPLETE TO			
PATIENT CICNATURE.		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