CNY Foot Surgery
& Podiatry Care P.C.

William M. Dutch, DPM
Melissa Cohen, DPM
Catherine McNerney, DPM

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WELCOME TO OUR OFFICE
Thank you for choosing CNY Foot Surgery and Podiatry Care for your podiatry needs.

Your appointment is with:

__ **Dr. William Dutch**
__ **Dr. Melissa Cohen**
__ **Dr. Catherine McNerney**

On _____ at _____ am/pm

If you are unable to keep this appointment time, kindly give the office 24 hours' notice. **A charge of $25.00 will be assessed for each no show or late cancellation appointment if less than 24 hours' notice is given.**

Please arrive **15 minutes** before your scheduled appointment time.

COMPLETE the patient registration in its entirety and bring to the appointment. **DO NOT MAIL OR FAX TO THE OFFICE.**

Please bring the following to your appointment:

- ✓ Your **COMPLETED** paperwork
- ✓ Insurance Card(s)
- ✓ Any **X-rays, CT scan, MRI's with the reports** pertaining only to your feet
- ✓ Medical records from other podiatrists, orthopedists, or primary care doctor
- ✓ **NO FAULT AND WORKERS COMPENSATION** cases must have your date of injury, name of insurance carrier with carriers address and phone number. IF YOU DO NOT HAVE THIS INFORMATION YOU WILL BE CONSIDERED A SELF PAY AND PAYMENT WILL BE EXPECTED AT TIME OF SERVICE.

Directions to our office
Our office is located on the corner of Kirkville Road and Fly Road in East Syracuse across from the KwikFill Gas Station. Take 481 and get off at the 5W exit. Turn left at the light and a quick left into our parking lot. We are building C and Suite 202.

We look forward to seeing you.

Sincerely,

The Staff of CNY Foot Surgery

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East Syracuse, NY 13057

Patient Information:
Name:_____
Address: _____
City: _____ State: _____ Zip:_____
Home Phone: _____ Cell: _____
Work Phone: _____
Date of Birth: ___/___/_____
Social Security #: _____
Birthplace: _____
Email: _____

Emergency Contact Information:
Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone: _____
Relationship: _____

Your Regular Physician:
Name: _____
Phone: _____

Your Pharmacy:
Name: _____
Phone: _____

Insurance Information

Name of Primary Insurance	Insurance ID #
Name of Subscriber	
Subscriber DOB	
Name of Secondary Insurance	Insurance ID #
Name of Subscriber	
Subscriber DOB	

Name of Employer: _____ Phone #: _____
Address: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

ASSIGNMENT OF BENEFITS: I, the undersigned, hereby authorize payment of medical and surgical benefits directly to William M. Dutch, DPM of CNY Foot Surgery and Podiatry Care, P.C.

Signed_____ Date_____

Physician/Clinician that referred you to our office:

Name: _____

Phone: _____

Do you see any other doctors? Who (first and last name of doctor)? And for what reason?

_____

_____

_____

What brings you to our office today?

_____

_____

Have you seen a podiatrist before? _____ Who? _____

Reason you saw him/her?

_____

_____

Past Medical History: PLEASE LIST ANY MEDICAL PROBLEMS YOU HAVE NOW OR HAVE AHD IN THE PAST:

Condition	No	Yes	Date (s)	Describe
Diabetes				
A Wound				
High Blood Pressure				
High Cholesterol				
Reflux Disease (GERD)				
Heart Attack				
Congestive Heart Failure				
Atrial Fibrillation				
Other Heart Disease				
Pacemaker				
Asthma				
COPD (Chronic Obstructive Pulmonary Disease)				
Emphysema				
Sleep Apnea				
Thyroid Disease				
Neuropathy				
Peripheral Arterial Disease (poor circulation)				
Females: Are you pregnant?				
Blood Clots				
Pulmonary Embolus (blood clot to lungs)				
Stroke				
Seizure Disorder				
Renal Failure				
Other Kidney Disease				
Arthritis				
Gout				
Rheumatoid Arthritis				

Auto Immune Disease (Lupus, Inflammatory Bowel Disease, etc.)				
Problems Requiring Treatment with Prednisone or another steroid				
Cancer				
Chemotherapy				
Chronic Sinus Problems				
MRSA				
Anxiety/Depression				
Other				

Diabetic Information:

What was the date you last saw PCP: _____

Do you monitor your glucose regularly? [ ] Yes [ ] No

If No, would you be willing to have the doctor explain the importance: [ ] Yes [ ] No

What was your last A1C and date of test? _____

It usually runs: Morning_____ Noon_____ Dinner_____ Bedtime _____

Test blood _____ times a Day / Week with: _____

Test urine _____ times a Day / Week with: _____

Do you see an Ophthalmologist for yearly eye exams: [ ] Yes [ ] No

Do you follow a routine diet plan: [ ] Yes [ ] No

Do you follow a routine exercise plan: [ ] Yes [ ] No

Would you be interested in learning about your diabetes, treatment options, complication management, and prevention: [ ] Yes [ ] No

Allergies: [ ] No [ ] Yes

Do you have a Latex Allergy? [ ] Yes [ ] No

Medication Allergy	Reactions

Current Medications:

Medication	Dose	Purpose

Surgical History:

Condition	No	Yes	Date (s)	Describe
Kidney Transplant				
Amputation				
Skin Grafts				
Blood Vessel Surgery				
Other Surgeries				

Family Medical History: Do you have a family history of: Diabetes, Heart Disease, Cancer, Bleeding problems, or any other medical disorder? Specify:

_____

SPECIFY THEIR MEDICAL CONDITIONS / DIAGNOSIS DESCRIPTION AND CAUSE OF DEATH

Mother: Alive / Deceased _____

Father: Alive / Deceased _____

Siblings: Alive / Deceased _____

Alive / Deceased _____

Alive / Deceased _____

Personal Habits:

Tobacco Use: **Past:** [ ] Yes [ ] No Amount per day: _____ Date Stopped: _____

Current Use: [ ] Yes [ ] No Amount per day: _____ How many years have you smoked:____

Alcohol Use: [ ] Yes [ ] No Usage per day: _____

Substance Usage: _____

Social History

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced

Do you have any children? [ ] No [ ] Yes How many: _____

Who do you live with: _____

Your Occupation: _____ Full Time Part Time Retired Disabled

At work do you: [ ] Sit [ ] Stand [ ] N/A

System Review – **ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?**

Current Head, Eyes, Ears, Nose & Throat

Condition	No	Yes	Description
Frequent Headaches			
Blurred / Double Vision			
Dizziness			
Change in Hearing			
Ringing in Ears			
Sore Throat			
Trouble Swallowing			
Other Current Symptoms			

Current Neurological

Condition	No	Yes	Description
Change in Memory			
Trouble with Balance			
Change in Sensation			
Other Neurological Symptoms			

Current Respiratory

Condition	No	Yes	Description
Colds			
Difficulty Breathing			
Cough / Dark Phlegm			
Other Current Respiratory Symptoms			

Current Cardiovascular

Condition	No	Yes	Description
Chest Pain			
Palpitations/ Irregular Heartbeat			
Swelling in Ankles / Legs			
Other Current Cardiovascular			

Current Digestive

Condition	No	Yes	Description
Heartburn			
Vomiting			
Constipation			
Diarrhea			
Black Stools			
Blood with Stools			
Other Current Digestive			

Current Bladder / Kidney

Condition	No	Yes	Description
Frequent Urination			
Burning Urination			
Blood in Urine			
Difficulty with Urination			
Other Current Bladder/Kidney			

Current Muscles / Bone/ Joints

Condition	No	Yes	Description
Leg Pain – At Rest			
Leg Pain – With Walking			
Back Pain			
Joint Aching Pain			
Swelling of Joints			
Difficult Joint Motion			
Other Current Muscle/Bones/Joints			

Current Skin

Condition	No	Yes	Description
Rash			
New Growths			
Color / Change in Moles			
Other Current Skin			

Other

Condition	No	Yes	Description

Do you have an Advanced Care Directive: [ ] Yes [ ] No If Yes, what type: [ ] HealthCare Proxy [ ] Living Will [ ] DNR

Where is it located: _____