

**RORY S. COHEN DPM**  
**DAWN YAMASHITA DPM & ASSOCIATES**

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

APT#

City/State/ZIP: \_\_\_\_\_

Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Cel Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Sex:  Male  Female

Place of Employment \_\_\_\_\_

Employment Address: \_\_\_\_\_

Work Telephone#: \_\_\_\_\_ EXT: \_\_\_\_\_

**If not working** are you a student?:  No  Yes, → if Yes  Full Time Student  Part Time student

**Family Physician:** Approximate **Date** you last saw you Primary Care Doctor? \_\_\_\_\_

Dr's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Dr's Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

ID# \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Flexible Spending**

*How did you learn about our office? (Please give names & check all that apply)*

Friend \_\_\_\_\_

Yellow pages

Internet

Doctor \_\_\_\_\_

Newspaper \_\_\_\_\_

Other \_\_\_\_\_

**Did you have Previous PODIATRY CARE?**  Yes  No

if yes, Dr's Name \_\_\_\_\_ Date \_\_\_\_\_

Treatment \_\_\_\_\_

---

---

**ASSIGNMENT OF BENEFITS**

**FOR MEDICARE PATIENTS ONLY:    YEAR 2010 DEDUCTIBLE is \$155.00**

Please note when the Doctor is taking ASSIGNMENT, it means that you are responsible for **yearly deductible** and for the **20% (Co-Insurance)** of what Medicare allows. If you have co-insurance, you are also responsible for services that your co-insurance doesn't cover.

Unlike some offices, the **FILING OF INSURANCE CLAIMS** is a **COURTESY** that we have always extended to our patients. However, all charges are **YOUR** responsibility, **NOT YOUR Insurance Company's**. We will make our **BEST EFFORT** to collect from them, but if, despite our best efforts, we are **NOT SUCCESSFUL**, **YOU** are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

**C O N S E N T**

I give permission to the doctor and associates or affiliates to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

-----

**SIGNATURE ON FILE**

1. I authorize use of this form on *all* my insurance submissions
2. I authorize release of information to all my *insurance companies*
3. I understand that *I am responsible* for my bill
4. I authorize my doctor to act as *my* agent in helping me obtain payment from my insurance companies
5. I authorize payment direct to my doctor
6. I permit a copy of this authorization to be used in place of the original

NAME \_\_\_\_\_  
PLEASE PRINT

INSURANCE ID NO.: \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Notice of Privacy Practices**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**RORY S. COHEN DPM**  
**DAWN YAMASHITA DPM & ASSOCIATES**

---

---

NAME: \_\_\_\_\_

F  M

D/O/B: \_\_\_/\_\_\_/\_\_\_

**YOUR HEALTH HISTORY**

1. Do you have any of the following medical conditions: (check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Respiratory   |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Hypercholesterolemia      | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Heart Attacks |
| <input type="checkbox"/> Other: _____  |  |  |

3. **ALLERGIES:**

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Penicillin         | <input type="checkbox"/> Codeine           | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sulfa Drugs        | <input type="checkbox"/> Iodine/ Shellfish | _____                                 |
| <input type="checkbox"/> Local Anaesthetics | <input type="checkbox"/> Tape              |                                       |
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Antibiotics       |                                       |

4. **DO YOU USE:**

- |   |                                  |  |
|---|----------------------------------|--|
| <input type="checkbox"/> CIGARETTES/TOBACCO | <input type="checkbox"/> ALCOHOL | <input type="checkbox"/> ILLEGAL DRUGS |
|---|----------------------------------|--|

5. Is there a family history of?

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> DIABETES    | <input type="checkbox"/> KIDNEY        | <input type="checkbox"/> SICKLE CELL   |
| <input type="checkbox"/> CANCER      | <input type="checkbox"/> HEART PROBLEM | <input type="checkbox"/> Foot Problems |
| <input type="checkbox"/> Other _____ |  |  |

6. **WHAT MEDICATIONS DO YOU CURRENTLY TAKE?**

\_\_\_\_\_

\_\_\_\_\_

7. **HAVE YOU EVER HAD SURGERY?**  NO  YES

IF YES, DATE AND TYPE OF SURGERY: \_\_\_\_\_

8. Have you ever been hospitalized?  NO  YES - if yes, when? \_\_\_\_\_

Reason: \_\_\_\_\_

9. **Foot Complaint:** Please Describe your foot problem

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RORY S. COHEN, D.P.M., P.C.**

DAWN A. YAMASHITA, D.P.M.  
And Associates or Affiliates  
420 Fulton Street, Brooklyn, NY 11201  
(718) 797-3668

**FINANCIAL AGREEMENT**

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of \$25 may then be added to your account.
- **Surgical Appointment Cancellation fee is \$300 – without 72 hour notice**
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day’s services.
- **CO-PAYMENTS** –By law we MUST collect your carrier designated co-pay: This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of \$20 may be added to your account.
- **OUT OF NETWORK PLANS** –You will be responsible for any balance your- plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan’s UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not ‘participate’ with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician’s office.  
Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Rory Cohen DPM & Associates for any services furnished. I understand that I am financially responsible for any amount not covered by my contract I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- **SELF-PAY PATIENTS** –Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one.  
Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Rory Cohen DPM & Associates for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** The parent who consents to the treatment of a minor child is responsible for payment of services rendered; Rory Cohen DPM & Associates will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient’s Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**RORY S. COHEN, D.P.M., P.C.**

DAWN A. YAMASHITA, D.P.M.

And Associates or Affiliates

420 Fulton Street, Brooklyn, NY 11201

(718) 797-3668

**REVIEW OF SYSTEMS: Check any of the following problems you have recently had:**

**General health problems**

- fatigue  fever  night sweats  unintentional weight loss  Sleeping problems  weight gain

**Eye problems**

- double vision  itchy eyes  swelling  redness

**Ear problems**

- ear drainage  hearing loss  ear infections  dizziness  itchy  noise exposure  ringing /noise in ears  
 ear pain  tinnitus

**Nose & Sinus problems**

- chronic congestion  mouth breathing  nosebleeds  frequent sneezing  runny nose  post-nasal drip

**Mouth & Throat problems**

- difficulty swallowing  snoring  sore throat  hoarseness  Sores in mouth  ulcers

**Heart or circulation problems**

- heart murmur  leg cramping  swelling of ankles  chest pain  blacking out  irregular heartbeat

**Lung or respiratory problems**

- shortness of breath  wheezing  cough

**Stomach problems**

- abdominal pain  diarrhea  heartburn  nausea  vomiting

**Brain or Nervous system problems**

- headache  seizures  weakness  numbness  facial pain

**Glands & Hormone problems**

- intolerance to heat  increased appetite  neck enlargement  intolerance to cold

**Blood or Lymph nodes problems**

- bleeds excessively after injury  bruises easily

**Allergy problems**

- food intolerances  insect bites

**Skin**

- rash  itchy  latex allergies  swelling  urticaria / hives