



Global Podiatry

Trust Your Feet in Our Hands

Simon Donets, DPM
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Name _____ Today's Date _____
 Address _____ City/State _____ Zip _____
 Home Phone _____ Work _____ Cell _____
 Social Security# _____ Age _____ Date of Birth _____ **Female** **Male**
 E-Mail _____ Preferred Contact Method: **Home#** **Cell#** **Email** **Mail**
 Employer _____ Address _____
 Marital Status: **S M W D** Spouses Name _____ Employer _____

Survey: How Did You Hear About Us? (Circle or fill-in)

Home Mailer/Newsletter **In-Office Sign/referral** **Newspaper** **Radio** **Website** _____
Prior Patient Referral (name) _____ **Physician Referral** (name) _____
Other _____

Primary Care Physician _____ Telephone# _____ Fax# _____
 PCP Address _____ Last Visit Date _____
 Emergency Contact _____ Relationship _____ Phone# _____
 Insurance Company _____ Policy# _____ Phone# _____
 Name of Insured _____ Insured Date of Birth _____ SS# _____
 Secondary Insurance? _____ Policy# _____ Phone# _____

I hereby give permission to Global Podiatry or Podiatric Management Systems to release any information requested by my insurance company required in the course of my exam and treatment. I also give permission to Global Podiatry or Podiatric Management Systems to evaluate, diagnose, and upon approval treat my foot and ankle condition. I request that payment of my insurance benefits be paid to Global Podiatry for services and/or supplies furnished to me.

Signature _____ **Date** _____ **Relationship** (if not patient) _____

Government Mandated HIPPA Disclosure

Acknowledgement of Receipt of Notice of Privacy Practices Provided by Global Podiatry

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, the Privacy Notice. This notice describes how this office will protect my healthcare information from unauthorized disclosures and use.

Signature _____ **Date** _____ **Relationship** (if not patient) _____