Dr. Daniel Jeran, D.P.M.
Board Certified,
American Board of Podiatric Medicine
Telephone: (631) 979-7654
Fax: (631) 979-4002

521 Route 111, Suite 309
Hauppauge, N.Y. 11788

70C Old Riverhead Road
Westhampton Beach, N.Y. 11977

PLEASE REFER TO THE FRONT DESK FOR ANY INFORMATION REGARDING THE OFFICE'S HIPPA MANUAL

Name: ______________________________ **Chart #:** ____________________

Date of Birth: ______________________ **Sex:** ◇ **Male** ◇ **Female** **SS#:** ______-______-_____________

Martial Status: ___________________ **Spouse/ partner Name:** ______________________________

Address: ______________________________ **City:** _________________ **State:** __________ **Zip:** __________

Home #: ________________________ **Cell #:** _______________________ **Other:** ______________________

Primary Care Physician: ______________________________ ***Town Location:*** ________________________

Pharmacy Name: ____________________________ ***Pharmacy Town:*** ________________________________

Email Address: ____

Emergency Contact Name: ___________________________________ **Phone #:** _______________________

Employer: ____ **Phone #:** ___________________________

Employer Address: _________________________________**City:** ________________ **State:** ________

Who can we leave a message with? ◇ **Wife** ◇ **Husband** ◇ **Daughter** ◇ **Son**

◇ **Other: Name (s):** ____

Smoking Status: ◇ **Current Every Day** ◇ **Some Day** ◇ **Smoker** ◇ **Former** ◇ **Never**

Vitals: **Blood Pressure:** __________/_________ **Height:** _____________ **Weight:** _____________**LBS**

Last Flu Shot Date: _________________________ Pneumococcal Vaccination? ◇ Yes ◇ No

Have you fallen in the past 6 Months? ◇ Yes ◇ No

Do you drink alcohol? ◇ Yes, Everyday (5-7 days). ◇ Yes, Occasionally. ◇ No/ Rarely.

Do you have/had a substance abuse problem? ◇ Yes, Currently or in the past.
Please Specify: ____. ◇ No.
Have you ever had any type of surgery? Please list them: ____

____

Have you ever had a surgical foot/ankle procedure? Please specify: ______________________________________

Current Medication(s): None **Name:**	**Dose:**
Name:	Dose:
Name:	Dose:
Name: ◇	Dose:
Name:	Dose:

Allergies: ◇ **None** Name:	Reaction:
Name:	Reaction:
Name:	Reaction:
Name:	Reaction:

Do you have any artificial joints? Yes, Where? ________________________. No.

Do you have an artificial heart valve? ◇ Yes ◇ No

Do you exercise? ◇ Yes, Specify: _______________________________________. ◇ No, rarely/ never.

Are you pregnant? ◇Yes ◇ No Are you nursing? Yes No

Please Circle ALL the Following that Apply

Thyroid Disorder	Sleep Apnea	Circulation Problems	Liver	Kidney Disease	Cancer Specify? _____________
Heart Murmur	Blood Clot	Anxiety Disorder	CVA	Breathing Issues	
High Cholesterol	Alcoholism	Blood Disorder	HIV	Diabetes Type 1	
Neuropathy Specify _____________	Gout	High Blood Pressure	Hepatitis	Diabetes Type 2	
Arthritis Specify _____________	Depression	Heart Disease	CVA	Skin Disorders	
Stomach/Bowel	Allergies	Mental Illness	Stroke	Musculoskeletal	

*Is there any family history **(blood relative)** of: **Please indicate which family member.***

How did you find this office? ____

Alzheimer's		**Depression**	
Arthritis		**Diabetes**	
Bleeding Disorders		**Emphysema**	
Blood Clot		**Heart Disease**	
Cancer		**High Blood Pressure**	
Cataracts		**Neurological**	
Circulation Problems		**Strokes**	
Other (Specify):			

What is the reason for your visit today?

____

____

Was this a Result of accident or work injury? Yes No

How long has this bothered you? 1 2 3 4 5 6 days weeks months years

What is the level of your pain 1-10? __________/10

The pain quality is (Please circle on of the following): burning constant dull sharp throbbing tingling shooting other (specify):____

OFFICE USE ONLY NOTES: ____

____

____

____

____

____

____

____

PRIMARY Insurance Name: ________________________________ **Are you the insured?** ◇ **Yes** ◇ **No**

Subscriber Name: __________________________________

Relationship to the insured? ◇ spouse ◇ child ◇ self ◇ other: ___________________________

Phone #: (______) _______-__________ Gender: ◇ Male ◇ Female DOB: ______/______/___________

Address: ____ Policy ID: ______________________________

SECONDARY Insurance Name: _____________________________ **Are you the insured? Yes No**

Subscriber Name: __________________________________

Relationship to the insured? ◇ spouse ◇ child ◇ self ◇ other: __________________________

Phone #: (______) _______-__________ Gender: Male Female DOB: ______/_______/___________

Address: ______________________________ Policy ID: __________________________

TERTIARY Insurance Name: ________________________________ **Are you the insured?** ◇ **Yes** ◇ **No**

Subscriber Name: __________________________________

Relationship to the insured? ◇ spouse ◇ child ◇ self ◇ other: _________________________________

Phone #: (______) _______-__________ Gender: ◇ Male ◇ Female DOB: ______/_______/___________

Address: ____ Policy ID: ______________________________

PLEASE READ AND SIGN
THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THROUGHOUT MY TREATMENT, I AM RESPONSIBLE FOR NOTIFYING THE PHYSICIAN AND/OR MEDICAL STAFF OF ANY AND ALL UPDATES TO THE INFORMATION LISTED ABOVE. HOWEVER IF I GIVE FALSE OR INCORRECT INFORMATION, I, THE PATIENT UNDERSTAND THAT I WILL BE HELD RESPONSIBLE.

I, THE PATIENT UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAYMENTS, COINSURANCES AND/ OR DEDUCTIBLES AS OUTLINED BY MY INSURANCE PLAN. FAILURE TO REMIT ANY OF THESE PAYMENTS MAY RESULT IN A PENALTY FEE. I ALSO UNDERSTAND THAT FAILURE TO SHOW-UP TO MY SCHEDULED APPOINTMENT WILL RESULT IN A FEE OF $25.00.

I, THE PATIENT HEREBY AUTHORIZE THE OFFICE OF DR. DANIEL JERAN, D.P.M. TO RETRIEVE, AND SHARE ANY AND ALL OF MY INFORMATION WITH OTHER DOCTORS AND FACILITIES IN COORDINANCE WITH MY CARE. AS WELL AS AUTHORIZE THIS OFFICE TO ACT AS A LIAISON WITH MY INSURANCE CARRIER (S): IE BENEFITS, CLAIMS, AUTHORIZATIONS AND SO FORTH ON MY BEHALF.

____ ____________________

PATIENT'S SIGNATURE **DATE**