Welcome to Kalker Podiatry.

We are always happy to welcome new patients to our growing practice. Please call us at 215-968-4048 so we may schedule a convenient appointment for you.

To prepare for your first visit, please download and fill out the new patient forms below. If you have Medicare, please fill out the authorization form. Please read the Summary of Notice Privacy Practices and sign the Acknowledgement of Receipt Form.

If your insurance requires a referral from your primary care physician, please obtain one before your appointment.

Along with the forms, please bring your insurance card with you to your office visit so we may make a copy of it for our records.

We will be happy to assist you with any questions about the forms. Please call us or we can assist you when you arrive for your appointment.

LAWRENCE C. KALKER, M.S., D.P.M, P.C.
WELCOME TO OUR OFFICE

TODAY'S DATE _____

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____ City _____ State: _____ Zip: _____

Home Phone ( ) _____ Cell ( ) _____ Email _____

Employer _____ Occupation _____

Employer's Address _____ Business Phone ( ) _____

Marital Status (circle one): S M D W Separated Sex: M F

MEDICAL INSURANCE

Subscriber Name _____ Relation _____ Date of Birth: _____

Address _____ City _____ State: _____ Zip: _____

Phone ( ) _____ Employer _____ Work ( ) _____

Type of Insurance _____ ID # _____ Group # _____

MEDICAL INFORMATION

Primary Physician _____ Last Visit _____

Address _____ City _____ State: _____ Zip: _____

Phone ( ) _____ Fax ( ) _____

Pharmacy Name _____ Phone ( ) _____

Please answer the following questions as completely as possible

1. Describe your foot or ankle problem _____

_____

2. How long have you had this problem? _____

3. Have you been treated before for this problem? If so, by whom and when? _____

_____

4. Is this a Workman's Compensation Claim/Personal Injury or Motor Vehicle related injury? Y N

5. Are you currently being treated for any illness? If so, please explain _____

_____

6. Past Surgery (list all surgeries you've had performed, including non-foot procedures) _____

_____

7. What is your activity level? (Circle One) High Medium Low Do you exercise? Y N Sometimes

Please Mark the Area of Concern Below

8. Are you **allergic** to any medications? (Please list all & reaction type) _____

_____

9. Please list all medications that you are currently taking. _____

_____

10. Do you smoke cigarettes? (Circle one) YES NO Packs per day?_____ Number of years? _____

11. Do you drink alcohol? YES NO Drinks per day? _____

12. Who referred you to our practice? _____

MEDICAL HISTORY (Check the appropriate column) Height:_____Weight:_____

	YES	NO
Anemia		
Arthritis		
Bleeding Problems		
Blood Transfusions		
Circulation Problems		
Cholesterol		
Diabetes (Type)		
Drug Dependency		
Epilepsy		
GI Ulcers		
Gout		
Heart Murmer		
Heart Trouble		

	YES	NO
Hepatitis (Type)		
High Blood Pressure		
HIV-AIDS		
Joint Replacement Surgery		
Kidney Problems		
Liver Problems		
Pacemaker		
Phlebitis		
Rheumatic Fever		
Sickle Cell		
Stroke		
Other:		

FAMILY HISTORY (Check the appropriate column)

	YES	NO
Arthritis		
Diabetes		
Cancer		

	YES	NO
Heart Disease		
Circulation Problems		
Other		

CONSENT

I hereby give permission to Dr. Lawrence C. Kalker to examine and administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problem(s).

Signature _____ Date _____

Relationship to Patient (if patient is a minor) _____

LAWRENCE C. KALKER, M.S., D.P.M., P.C.

Diplomate, American Board of Podiatric Orthopedics & Primary Podiatric Medicine

6 South Sycamore Street, Suite 2
Newtown, PA 18940
Telephone: (215) 968-4048
Fax: (215) 968-4396

Name of Beneficiary _____ Health Insurance Claim Number _____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lawrence C. Kalker, D.P.M., for any services furnished to me by that physician or supplier.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Beneficiary Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF 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 understand The Notice of Privacy Practices.

_____ _____

Patient's Name (Please Print) **Date**

My medical information may be shared with the following people and/or agencies:

Primary Care Physician:_____

Others:_____

_____

_____

Patient's Signature (or Authorized Representative)

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

Foot & Ankle Specialists

Lawrence C. Kalker, M.S., D.P.M., P.C.
Diplomate American Board of Podiatric Orthopedics & Primary Podiatric Medicine

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