FOOT AND ANKLE PHYSICIANS, P.A.

100 Morris Ave, Springfield, NJ 07081 **550 NEWARK AVE. JERSEY CITY, NJ 07306**
973-258-0111 **201-222-7888**

CONFIDENTIAL PATIENT INFORMATION SHEET

LAST NAME:_____ FIRST NAME:_____M.I.:_____

ADDRESS:_____CITY/STATE/ZIP:_____

PHONE #:_(_____)_____ CELL PHONE #: (_____)_____

BIRTHDATE:_____/_____/_____ S.S. #:_____-_____-_____ SEX: M___ F___

MARITAL STATUS: S___ M___ DIVORCED___ OTHER____ RACE/ETHNICITY: _____

PREFERRED LANGUAGE: _____ EMERGENCY CONTACT: _____

PHONE #: (_____)_____ RELATIONSHIP: _____

PRIMARY DOCTOR NAME:_____DR. PHONE#:(_____)_____

IS THIS VISIT RELATED TO AN ACCIDENT? YES:_____ IF YES, DATE:___/____/_____ NO:____

EMPLOYER OR SCHOOL NAME:_____

STREET ADDRESS:_____BUSINESS PHONE#:(_____)_____

PHARMACY NAME/ADDRESS/PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURED'S FULL NAME:_____DATE OF BIRTH: _____/_____/_____

INSURED'S EMPLOYER: _____S.S #:_____-_____-_____

INSURANCE CO.: _____ POLICY/ ID#: _____

GROUP#: _____ TEL #: (_____)_____

RELATIONSHIP TO INSURED: SELF____ SPOUSE____ CHILD____ DEPENDENT____ OTHER____

SECONDARY INSURANCE INFORMATION

INSURED'S FULL NAME:_____DATE OF BIRTH: _____/_____/_____

INSURED'S EMPLOYER: _____S.S #:_____-_____-_____

INSURANCE CO.: _____ POLICY/ ID#: _____

GROUP#: _____ TEL #: (_____)_____

RELATIONSHIP TO INSURED: SELF____ SPOUSE____ CHILD____ DEPENDENT____ OTHER____

PATIENT STATEMENT

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF BENEFITS TO FOOT AND ANKLE PHYSICIANS, P.A., AS AGREED UPON AT THE TIME OF TREATMENT FOR SERVICES RENDERED.

_____ _____/_____/_____

PATIENT SIGNATURE/AUTHORIZED REPRESENTATIVE DATE

FOOT AND ANKLE PHYSICIANS, P.A.

Medical History: Do you have or have you ever been treated for?

❑ **Stroke**	❑ **Heart Attack**	❑ **High Blood Pressure**	❑ **A Heart Condition**
❑ **Phlebitis**	❑ **Poor Circulation**	❑ **Vascular Disease**	❑ **Diabetes**
❑ **Hepatitis**	❑ **Liver Disease**	❑ **Gout**	❑ **Headaches**
❑ **Arthritis**	❑ **Osteoporosis**	❑ **Anemia**	❑ **High Cholesterol**
❑ **Sciatica**	❑ **Rheumatic Fever**	❑ **Keloid/Thick Scar**	❑ **Alzheimer's**
❑ **Epilepsy**	❑ **Nerve Disorder**	❑ **Hearing/Ear Disorder**	❑ **Glaucoma**
❑ **Asthma**	❑ **Kidney Disease**	❑ **Psychiatric Disorder**	❑ **Thyroid Problem**
❑ **Cancer**	❑ **Tuberculosis**	❑ **Lung Disease**	❑ **Stomach Ulcer**
❑ **Cataracts**	❑ **Urinary Disorder**	❑ **AIDS/HIV Positive**	❑ **NONE of these**
❑ **Other(s):**			

Your Current: Weigh _____lbs. Height: ____'____" Shoe Size:_____

Allergies: Any allergies to ❑ Penicillin ❑ Sulfa ❑ Codeine ❑ Novocaine or Lidocaine
❑ Aspirin ❑ Shellfish (shrimp, lobster, clams, scallops) ❑ Adhesive tape
❑ Other medication (if yes, please list _____)
❑ Other food (if yes, please list _____)

Surgical History: List previous surgeries (type, date, and any complications)

1._____

2._____

3._____

4._____

Social History: Smoke ? ___ No ___Yes Packs /day ___ Years ____

Alcoholic Beverages? ___None ___Rarely ___Moderately ___Daily ___Quit

Recreational Drug? ___ None ___Rarely ___Moderately ___Daily ___Quit

Family Medical History: List relationship to you of family members who have had:

Diabetes _____ Foot Problems _____

Arthritis_____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

Medication List: Are you currently taking medications? No Yes (list below name, dose, how often)

1._____ 2. _____

3._____ 4. _____

5._____ 6._____

I acknowledge that the above statements are true. I hereby give my doctor permission to administer treatment and to perform such procedures as may be necessary in the diagnosis and/or treatment of my foot/leg condition.

_____ _____/_____/_____

PATIENT SIGNATURE/AUTHORIZED REPRESENTATIVE DATE

REVIEW OF SYMPTOMS

(Confidential)

Patient Name_____ DOB_____

Please check whatever pertains to you:

Constitutional: Have you been experiencing

___Fever ___ Weakness __ Fatigue ___Change in weight (loss/gain)

Eyes: Have you recently had

___Blurred or double vision ___Unusual sensitivity to light ___ Any excessive tearing

___Problem with dry eyes

Ears, nose, Mouth, Throat: Any problems with hearing

___ Ringing in the ears ___Dizziness ___ Earaches ___Infection or discharge

Any problems with your nose

___Discharge ___ bleeding ___ sinus problems

Any problems with your mouth

___Excessive dryness ___ Increased salivation ____Ulceration (open sores) ____ Bleeding

Any problems with your throat

___Hoarseness in speaking ___Difficulty in swallowing

Cardiovascular: Are you experiencing?

___Swelling of the legs or feet ___palpitations ___Difficulty in breathing when lying flat

___Sudden awakening from sleep with suffocation feeling ___Heart murmur

___Chest pain (angina)

Respiratory: Are you experiencing?

___A cough with or without mucous ___Spitting blood ___Night sweats ___Chills

___Wheezing ___shortness of breath ___pain with breathing

Gastrointestinal: Are you experiencing?

___Change in appetite ___heartburn ___excessive belching or gas ___sour stomach

___Nausea vomiting ___ belly pain ___vomiting blood ___change in bowel habits

___Rectal bleeding ___ tarry(dark) or bloody stools

Integumentary: Do you have

___rashes ___ lumps ___ itching ___ dryness ___changes in skin color ___nail problems

Genitourinary: Do you experience

___excretion of large quantitiy of urine ___ increase frequency of urination at night

___ blood in urine _____ pain on urination _____ inability to control urge to urinate

___ difficulty in starting the stream

Musculosketetal: Do you experience

___ joint pain ___joint stiffness ___backache ___pain when walking in the calves

___ night muscle cramps

Neurological: Do you have any

___ numbness ___ tingling ___tremors ___local weakness ___paralysis ___fainting

___ blackouts

Psychiatric: Do you experience

___ nervousness ___tension ___mood swings ___depression

Endocrine: Do you experience excessive

___ sweating ___thirst ___hunger ___urination ___difficulty in toleration cold or heat

Hematologic/Lymphatic: Any problems with

___anemia ___easy bruising ___transfusion reactions

_____ _____ _____

Patient Signature **Date** **Time**

I, Dr. Jonathan Sorkin hereby attest to the review and accuracy of the above information.

_____ _____ _____

Physician Signature **Date** **Time**