

FOOT AND ANKLE PHYSICIANS, P.A.

100 Morris Ave, Springfield, NJ 07081
973-258-0111

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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?

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> A Heart Condition |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Keloid/Thick Scar | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Hearing/Ear Disorder | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Urinary Disorder | <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> NONE of these |
| <input type="checkbox"/> 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 quantity 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

Musculoskeletal: 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