FOOT AND ANKLE PHYSICIANS, P.A.
100 MORRIS AVE SPRINGFIELD, NJ 07081
973-258-0111

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:_____

E-MAIL:_____PREFERRED CONTACT METHOD: ELECTRONIC/PAPER

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. CONFIDENTIAL PATIENT INFORMATION SHEET

PATIENT NAME: _____ PRIMARY CARE DOCTOR: _____

PLEASE SPECIFY THE REASON FOR TODAY'S VISIT

WHICH IS THE AFFECTED AREA? ANKLE_____ HEEL_____ FOOT _____ NAILS/SKIN_____ OTHER: _____ LEFT SIDE_____ RIGHT SIDE_____ BOTH_____

WHAT ARE YOUR SYMPTOMS AND WHEN DO THEY OCCUR?_____

_____

YOUR HEIGHT:_____ WEIGHT:_____ SHOE SIZE:_____

CIRCLE ALL THOSE THAT APPLY

	DO YOU HAVE ANY OF THE FOLLOWING COMPLAINTS	DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS
Constitutional	fever, weakness, loss of appetite, unexplained weight change	
Eye	double vision, difficulty seeing, infection	glaucoma, cataract, macular degeneration
Ear, Nose, or Throat	hearing loss, pain, infection, nose bleeds, difficulty swallowing	vertigo, polyps, rhinitis , sinusitis , sleep apnea
Cardiovascular	palpitations, chest tightness/ pain, swelling in legs	high blood pressure, afib, angina, coronary artery disease, murmur
Respiratory	shortness of breath, difficulty breathing, frequent cough	asthma, COPD
GI	heartburn, diarrhea, constipation, nausea, vomiting	ulcer, liver disease/ hepatitis, IBD, gallstones
Urinary	difficulty urinating, frequency, pain	kidney stones, UTI's, BPH, Bladder weakness or disease
Muscular skeletal	back pain, chronic joint pain or swelling	sciatica, rheumatoid arthritis
Skin/Nails	rash, itch, changes in skin or nail color, slow healing wounds	psoriasis, eczema
Neurologic	numbness, tingling, burning, tremor, shaking	neuropathy, fibromyalgia, stroke, mini-stroke, MS, Parkinson's
Psychiatric:	anxiety, depression	anxiety, depression, bi- polar, schizophrenia, Alzheimer's
Endocrine	excessive thirst or urinating. Heat or cold intolerance,	Type I Diabetes, Type II Diabetes, hypo/hyperthyroid,
Hematologic	excessive bleeding, bruising	anemia, ITP, blood clots, phlebitis,
Cancer	masses, lumps, wounds, bleeding , enlarged glands	prostate or breast cancer , leukemia, lymphoma, any other cancer Melanoma, basil cell or squamous cell carcinoma
Immune disorder:	slow healing, frequent infections	HIV/ AIDS, Lupus, Rheumatoid arthritis, Scleroderma

LIST ANY OTHER MEDICAL PROBLEMS: _____

LIST ALL THE MEDICATIONS YOU ARE TAKING: _____

_____ LIST ANY ALLERGIES YOU HAVE:_____

LIST ALL OPERATIONS YOU HAVE HAD: _____

SMOKE TOBACCO?_____ HOW OFTEN?_____ DRINK ALCOHOL?_____ HOW OFTEN?_____DRUG USE?_____ HOW OFTEN?_____

FAMILY MEDICAL HISTORY:_____

I ACKNOWLEDGE THAT THE ABOVE STATEMENTS ARE TRUE. I HEREBY GIVE MY DOCOTR PERMISSIONTO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION.

_____ _____

PATIENT SIGNATURE/ AUTHORIZED REPRESENTATIVE DATE

FOOT AND ANKLE PHYSICIANS, P.A.

SIGNATURE ON FILE
&
PRIVATE NOTE ACKNOWLEDGEMENT

1. **ADMISSION CONSENT:** I AUTHORIZE FOOT AND ANKLE PHYSICIANS TO PROVIDE CARE AND TO ADMINISTER SUCH ROUTINE DIAGNOSTIC, RADIOLOGICAL AND/OR THERAPEUTIC PROCEDURES AND TREATMENT INCLUDING, BUT NOT LIMITED TO, THE ADMINISTRATION OF PHARMACEUTICAL PRODUCTS, AND INTRAVENOUS MEDICATION, AS IN THE JUDGEMENT OF THE PHYSICIANS THEY DEEM NECESSARY OR ADVISABLE IN MY DIAGNOSIS, CARE AND TREATMENT. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE OF BENEFICIAL RESULTS HAS BEEN PROMISED OR IMPLIED AS A RESULT OF THE ABOVE-MENTIONED DIAGNOSIS AND THERAPEUTIC PROCEDURES. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURES AND TREATMENT. I UNDERSTAND THAT NO GUARANTEES HAVE BEEN MADE TO ME ABOUT THE OUTCOME OF THIS CARE.

2. **RECURRING VISITS:** IF THE SERVICES RENDERED QUALIFY ME FOR RECURRING STATUS, MY SIGNATURE HEREON SHALL BE VALID FOR CARE RENDERED THROUGHOUT THIS PERIOD. IF DURING THIS PERIOD, ANY OF MY INFORMATION CHANGES. I.E. ADDRESS, PHONE, EMPLOYMENT, INSURANCE GUARANTOR, ETC. I WILL NOTIFY THE OFFICE OF THE CHANGE.

3. **RELEASE OF INFORMATION:** I UNDERSTAND THAT MY MEDICAL RECORDS ARE KEPT IN BOTH HARD COPY AND ELECTRONIC FORM AND THAT PHYSICIANS AND PERSONS INVOLVED IN MY CARE HAVE ACCESS TO BOTH FORMS OF RECORDS. THE OFFICE MAY SEEK, RELEASE AND VERIFY ALL OR PART OF THE MEDICAL AND/OR FINANCIAL RECORDS TO ANY PERSON, CORPORATION, OR GOVERNMENT AGENCY WHICH IS OR MAY BE LIABLE UNDER A STATUTE, REGULATION, OR CONTRACT TO THE OFFICE, THE PATIENT, A FAMILY MEMBER, OR EMPLOYER OF THE PATIENT, FOR ALL OR PART OF THE CHARGES. **I CONSENT TO THE RELEASE OF MEDICAL INFORMATION FOR PURPOSES OF DISCHARGE PLANNING. I CONSENT TO THE RELEASE OF MY IDENTIFICATION, AND GENERAL CONDITION.**

4. **FINANCIAL AGREEMENT:** FOR AND IN CONSIDERATION OF SERVICES RENDERED, I AGREE TO MAKE PROMPT PAYMENT WHEN BILLED FOR ANY AND ALL CHARGES NOT COVERED BY VALID INSURANCE BENEFITS. I UNDERSAND THAT I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLES, COPAYMETNS, AND/OR COINSURANCE. IF I AM A CLASSIFIED AS A SELF-PAY PATIENT, A DEPOSIT WILL BE REQUESTED**. I REALIZE IT IS MY OBLIGATION TO OBTAIN A REFERRAL, PRE-CERTIFICATION OR A SECOND OPINION SHOULD IT BE REQUIRED PRIOR TO SERVICES.** IF FOOT AND ANLE PHYSICIANS, OR MY INSURANCE CARRIER OR ITS INTERMEDIARIES, OR THE QUALITY IMPROVEMENT ORGANIZATION DEEMS THAT MEDICAL AND/OR PROFESSIONAL SERVICES TO BE GIVEN OR ALREADY GIVEN ARE NOT MEDICALLY NECESSARY AND/OR NON-COVERED SERVICES.

5. **AUTHORIZATION FOR TESTING:** IN THE EVENT THAT ANY HEALTHCARE PROVIDER OR FIRST RESPONDER (INCLUDING EMERGENCY MEDICAL SERVICE WORKERS AND POLICE OFFICERS) INVOLVED IN MY CARE IS EXPOSED TO MY BLOOD OR BODILY FLUIDS AND MAKES A REQUEST FOR TESTING AND RESULTS OF SUCH TESTING, I CONSENT TO THE DRAWING OF BLOOD FOR THE PURPOSE OF TESTING IT FOR SERIOUS BLOOD-BORNE PATHOGENS INCLUDING, BUT NOT LIMITED TO, HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND HEPATITIS B AND C. I UNDERSTAND AND AGREE THAT THE RESULTS OF THE BLOOD TEST SHALL BE RELEASED TO ME AND THE HEALTHCARE

FOOT AND ANKLE PHYISICIANS, P.A.

PROVIDERS; FIRST RESPONDER EXPOSED TO MY BLOOD OR BODLY FLUIDS. TO THE EXTENT POSSIBLE, THESE RESULTS WILL BE PROVIDED TO THE HEALTHCARE PROVIDER/FIRST RESPONDER WITHOUT DISCLOSING MY NAME.

6. **ASSIGMENT OF BENEFITS:** I HEREBY ASSIGN, TRANSFER AND SIGN OVER TO FOOT AND ANKLE PHYSICIANS, P.A. ALL AND SUFFICIENT MONIES, CLAIMS AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, UNION WELFARE FUNDS OR ANY OTHER PARTIES THAT ARE FINANCIALY LIABLE TO PAY THE CHARGES FOR THE CARE, TREATMENT AND SUPPLIES THAT I WAS RENDERED AND FURNISHED OR THAT WERE RENDERED AND FURNISHED TO THE PATIENT FOR WHOM I HAVE FINANCIAL RESPONSIBILITY.

7. **MEDICARE-AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST:** I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS OR MY PHYSICIAN(S) ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZE BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIANS OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT TO ME. **THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THE EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.**

8. I UNDERSTAND THAT IF I DO NOT COMPLY WITH THE PRE-CERTIFICATION REQUIREMENTS, I WILL BE RESPONSIBLE FOR MEDICAL CHARGES.

9. I ACKNOWLEDGE RECEIPT OF THE "PRIVACY NOTICE."

10. I HAVE READ THIS FORM, MY QUESTIONS HAVE BEEN ANSWERED AND I UNDERSTAND AND AGREE TO ITS CONTENT.

Patient Name: _____

_____ _____ _____

Patient Signature/Authorized Representative Relationship Date