



FAMILY FOOT & ANKLE CENTER  
*of Central Jersey*

**PERSONAL INFORMATION:**

**PHARMACY NAME / LOCATION:** \_\_\_\_\_

Name \_\_\_\_\_ M / F \_\_\_\_\_ S.S. # \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Email Address \_\_\_\_\_  
 BIRTH DATE: \_\_\_/\_\_\_/\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_  
 Marital Status: M/D/S/W Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer's Address \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 DATE LAST SEEN \_\_\_\_\_  
 Please Describe Your Foot/Ankle Problems \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance Provider \_\_\_\_\_ Subscriber \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Subscriber's S.S. # \_\_\_\_\_ Subscriber's Birth Date \_\_\_\_\_  
 Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Address \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

Secondary Insurance Provider \_\_\_\_\_ Subscriber \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Subscriber's S.S. # \_\_\_\_\_ Subscriber Birth Date \_\_\_\_\_  
 Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Address \_\_\_\_\_

**PATIENT AUTHORIZATION/CANCELLATION: I HAVE READ AND AGREE TO THE BELOW STATEMENTS**

- I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance and its agents any information needed to determine these benefits or the benefits payable for related services.
- I give permission to the Doctor to access medication history from pharmacies, to examine, treat and perform general procedures, as she deems necessary in the diagnosis and/or treatment of my condition. I understand there are no guarantees associated with any working diagnosis or treatment.
- If you fail to give our office 24 hours notice, you will be charged a fifty dollar (\$50) fee; this fee will not be covered by your insurance company.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name \_\_\_\_\_

**PLEASE CHECK ALL THE CONDITIONS WHICH PERTAIN TO YOUR MEDICAL HISTORY**



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- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Anemia/Blood Disease or Infection |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Kidney/Liver Disease              |
| <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Gastric/Stomach Ulcer             |
| <input type="checkbox"/> Mitral Valve Prolapse/Heart Murmur | <input type="checkbox"/> Gastritis/Hiatal Hernia           |
| <input type="checkbox"/> Emphysema/Lung Disease/Pneumonia   | <input type="checkbox"/> Seizure Disorders                 |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Wound Care Problems               |
| <input type="checkbox"/> Painful Arthritis                  | <input type="checkbox"/> (Other) _____                     |

**CURRENT PRESCRIPTION MEDICATIONS (and OTC Meds)**

- 1) \_\_\_\_\_ 3) \_\_\_\_\_ 3) \_\_\_\_\_
- 2) \_\_\_\_\_ 4) \_\_\_\_\_ 6) \_\_\_\_\_

**ALLERGIES**

- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

Please describe your "allergic reaction" : \_\_\_\_\_

**HOSPITALIZATIONS and SURGERIES (or Minor Foot Surgery) WITHIN THE PAST 5 YEARS**

- |       |            |
|-------|------------|
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |

**How did you find out about Family Foot & Ankle Center of Central Jersey? Please check all that apply!**

- |  |  |                                       |                                      |
|--|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Family Physician  | <input type="checkbox"/> Other Doctor/Nurse/Therapist (name) _____ |                                       |                                      |
| <input type="checkbox"/> Insurance List    | <input type="checkbox"/> Friend/Relative (name) _____              |                                       |                                      |
| <input type="checkbox"/> Hospital Referral | <input type="checkbox"/> Newspaper                                 | <input type="checkbox"/> Yellow pages | <input type="checkbox"/> Other _____ |

Have you or has anyone in your family been treated in our office before? YES / NO

If yes, who? \_\_\_\_\_



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND PATIENT POLICIES AND PROCEDURES

I hereby acknowledge that I have received, read and had an opportunity to ask questions concerning the above named practice's **NOTICE OF PRIVACY PRACTICE POLICIES AND PROCEDURES**.

The above named practice may discuss my treatment with the following people. (Include any family, friends or other contacts.)

NAME	PHONE	RELATION TO PATIENT
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_____	_____	_____
_____	_____	_____

\_\_\_\_\_ I may be contacted at the following locations:

Yes \_\_\_\_\_ No \_\_\_\_\_ Home phone #

Yes \_\_\_\_\_ No \_\_\_\_\_ Work phone #

May we leave a message regarding your medical care/test results on your answering machine? _____ Yes _____ No
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\_\_\_\_\_  
Patient or Patient's Representative Signature

\_\_\_\_\_  
Date

Print Patient's Name: \_\_\_\_\_

If signed by Representative, state name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am financially responsible for my account for any professional services rendered that are not otherwise paid or reimbursed. I hereby authorize my insurance company to assign my benefits directly to Holli Alster, DPM, LLC/Family Foot and Ankle Center of Central Jersey, benefits payable to me. I also agree to be responsible for payment of all services rendered on my behalf for my dependents. I understand and agree that should my account be turned over to a collection agency, I may be responsible for up to an additional 32% of the unpaid balance.

\_\_\_\_\_  
Patient or Patient's Representative Signature

\_\_\_\_\_  
Date