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 ____

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PLEASE CHECK ALL THE CONDITIONS WHICH PERTAIN TO YOUR MEDICAL HISTORY

_______ Diabetes

_______ Hypertension (High Blood Pressure)

_______ Heart Disease

_______ Mitral Valve Prolapse/Heart Murmur

_______ Emphysema/Lung Disease/Pneumonia

_______ Asthma

_______ Painful Arthritis

_______ Anemia/Blood Disease or Infection

_______ Kidney/Liver Disease

_______ Gastric/Stomach Ulcer

_______ Gastritis/Hiatal Hernia

_______ Seizure Disorders

_______ Wound Care Problems

_______ (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!

_____ Family Physician _____ Other Doctor/Nurse/Therapist (name)___________________________________

_____ Insurance List _____ Friend/Relative (name)____

_____ Hospital Referral _____ Newspaper ______Yellow pages _____ Other _________________________

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

If yes, who? ____

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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**

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

_________________________________ _________________________

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