

WELCOME TO OUR OFFICE

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

PATIENT NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: () _____ WORK PHONE: () _____

CELL PHONE: () _____

DATE OF BIRTH: _____ AGE: _____ SEX: M F Height: _____ Weight: _____

MARITAL STATUS: _____ SSN: _____

PREFERRED LANGUAGE _____ RACE: _____ ETHNICITY: _____

EMERGENCY CONTACT: _____

RELATION: _____ PHONE#: () _____

MEDICAL HISTORY

PHARMACY NAME: _____ PHONE # _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

MEDICATION ALLERGIES: _____

CURRENT MEDICATION: _____

PRIOR SURGERIES (INCLUDE DATES): _____

PLEASE CIRCLE MEDICAL CONDITIONS THAT YOU HAVE, OR HAVE HAD IN THE PAST

HIGH BLOOD PRESSURE

KIDNEY DISEASE

BLEEDING PROBLEMS

DIABETES

LIVER DISEASE

SKIN DISORDER

HEART DISEASE

THYROID DISEASE

RHEUMATOID ARTHRITIS

LUNG DISEASE

STOMACH ULCERS

OSTEOARTHRITIS

REFERRAL SOURCE

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

Social History

EMPLOYER: _____ **ADDRESS:** _____

Tobacco Use: Yes: ____ No: ____ Cigarettes _____ Cigars _____ Chewing Tobacco (snuff) _____

Started Age/Year _____ Stopped _____ Quantity per day: _____

Alcohol Use: Do you consume Alcoholic Beverages? Yes ____ No ____

Social Drinker _____ Moderate Drinker _____ Heavy Drinker _____ Abstains _____

Illicit Drug Use: Yes ____ No ____

Have you ever been treated for drug or alcohol addiction? Yes ____ No ____

INSURANCE INFORMATION

WAS THIS INJURY THE RESULT OF AN ACCIDENT? YES NO

WAS THIS AUTO RELATED? YES NO WORK RELATED? YES NO

WHEN DID THIS INJURY OCCUR? : (MM/DD/YY) _____

PLEASE GIVE DETAILS OF ACCIDENT: _____

WHAT SYMPTOMS ARE YOU EXPERIENCING? _____

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

PRIMARY INSURANCE

CARRIER: _____

INSURANCE ID #: _____ **INS. PH# ()** _____

POLICY HOLDERS NAME: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____

POLICY HOLDERS DATE OF BIRTH: _____ **RELATIONSHIP:** _____

SECONDARY INSURANCE

CARRIER: _____

INSURANCE ID # _____ **INS. PH# ()** _____

POLICY HOLDERS NAME: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____

POLICY HOLDERS DATE OF BIRTH: _____ **RELATIONSHIP:** _____

AUTHORIZATION TO TREAT

Date: _____

Patient's name: _____

Claims Authorization

I hereby authorize any physician, healthcare practitioner, hospital, clinic, or other medical facility to furnish any and all records, medical history, and services rendered or treatment given to me or any dependant for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or healthcare service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, and association, trust fund, union or similar entity, this authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or tern of coverage with my insurer(s) including a reasonable time thereafter, until it's final consummation. This authorization shall be binding upon me, my dependants, and our heirs, executors and administrators.

Assignment of Benefits – Private and Federal (Medicare)

I authorize payments of medical and surgical benefits, including Medicare benefits, to be made on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable for related services.

Litigation Disclaimer

It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record and X-ray in the possession and control of this office, pursuant to receipt of property notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

(Signature of patient or guardian)

(Print name)

Photocopy or fax of this form shall be considered as effective and valid as the original.

NEW JERSEY FOOT & ANKLE CENTER

RALPH C. NAPOLI, D.P.M.
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Fellow American College of Foot & Ankle Surgeons

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OFFICE POLICY ON PATIENT CARE

In order to accommodate the needs and request of our patients, we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep up to date with all of the specific and various requirements of each and every plan, WITHOUT YOUR FULL COOPERATION. Please understand that each plan has different stipulations such as referrals, authorizations, lab work, etc. IT IS VERY IMPORTANT THAT YOU, THE PATIENT COME INTO OUR OFFICE WITH ALL OF THE REQUIRED DOCUMENTATION AND BE FULLY AWARE OF HOW YOUR PLAN WORKS PRIOR TO THE TIME OF YOUR SCHEDULED APPOINTMENT. YOU, THE PATIENT ARE THE POLICYHOLDER AND IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN.

With your cooperation, we, your health care provider, can provide you with all the medical benefits to which you are entitled which is our primary concern.

*****I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATE ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED ABOVE.**

Signature

Date