Welcome to Shore Podiatry -- Patient Information Form

Name:______________________________________ Today's Date: ______________________

Social Security #:_____________________________ Date of Birth:______________________

Street Address: ____ Apt #:______________

City:____________________________________ State:___________ Zip:_________________

Home Phone:_________________________ Work Phone:_____________________________

Cell Phone:____________________________ Sex: M/F Marital Status:___________________

E-mail Address:____

Employer:_____________________________ Occupation:____________________________

Business Address:_______________________________ Business Phone:_________________

Emergency Contact:________________________ Phone Number: ______________________

Primary Insurance:__________________________________ Effective Date:________________

Policy Number:___________________________________ Group Number:________________

Name of Insured:____________________________ Relationship to Patient:_____________

Insured Birthday:__________________ Insured Social Security #:_______________________

Insured Address (if different):____

Secondary Insurance:_______________________________ Effective Date:_______________

Policy Number:___________________________________ Group Number:________________

Name of Insured:___________________________ Relationship to Patient:_______________

Insured Birthday:_________________ Insured Social Security #:________________________

Insured Address (if different):____

Medical History

Name______________________________________ Today's Date ____/____/_____

Check any of the following you have now or have had in the past:

__Anemia	__Diabetes	__Liver Disease
__Angina	__Epilepsy/Seizures	__Lung Disease
__Alzheimer's/Dementia	__Emphysema/COPD	__Nervous Condition/Anxiety
__Artificial Heart Valves	__Glaucoma	__Osteoarthritis
__Artificial Joint	__Gout	__Osteoporosis
__Asthma	__GERD (reflux)	__Psychiatric Care
__Back Pain	__Heart Disease	__Rheumatoid Arthritis
__Bleeding Disorders	__High Blood Pressure	__Stomach Ulcers
__Cancer (type) ____________	__High Cholesterol	__Stroke/TIA
__Circulation Problems	__Hepatitis (type A,B,C)	__Thyroid Disease (hypo/hyper)
__Depression	__HIV/AIDS	__Tuberculosis
__Drug use	__Kidney Disease	__Venereal Disease

Medical Conditions not listed above:

____

Allergies (check those that apply): ______ No Allergies

__Adhesive/Tape	__Cortisone	__Narcotics	__Sulfa
__Aspirin	__Iodine/Seafood	__Novocain/Anesthetics	__Others _______________
__Codeine	__Latex	__Penicillin	

Height _________ Weight _________ Blood Pressure ________/_________

Is there a family history of ? (check if yes): **Hypertension (__mother, __father, __sister, __brother)**

Diabetes (__mother, __father, __sister,__brother)

Cancer (__mother, __father, __sister,__brother)

Patient Name: ______________________.   Today's date: ____/_____/________.

Please list (or provide a list) of your current medications and their dosages (<u>or write none</u>):

____

____

Please list any surgery that you have had (<u>or write none</u>):

____

____

Social History:

Smoking history: Do you currently smoke? Yes _______ No ________

If you smoke, how many packs/day? ______________

If you do not currently smoke, did you ever smoke? Yes ________ No _______

Alcohol use: Do you drink alcoholic beverages? Yes _______ No ________

How many drinks do you consume in a day? ______ in a week? _______ in a month? _______

Recreational Drug Use: Do you or have you used illicit/recreational drugs? Yes _____ No _____

If yes which ones _______________ How long ago did you quit? ___________________

Do you have a living will? Yes ____ No ____

Women: Are you currently pregnant? Yes ______ No______ Due date? ___________

Date of last flu immunization: _______ Date of last pneumonia immunization: _________

Name of primary MD: ____

Town primary MD is located in: ____________________Phone #:_______________________

Name of Pharmacy: ____

Town pharmacy is located in: ______________________Phone #:_______________________

How did you hear about us? ____

Reason for your visit:____

Shore Podiatry Signature Sheet

Patient Name ______________________ Date of Birth ______________

Certification and Consent

I certify that the information submitted on the patient information and medical history forms is true and correct to the best of my knowledge. I give permission for the doctors to administer and perform such procedures as deemed necessary in the diagnosis and treatment of my feet/ankles.

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Shore Podiatry all insurance benefits, if any, otherwise payable to Shore Podiatry for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If I receive any payments from my insurance company in error, I will sign them directly over to Shore Podiatry. I hereby authorize the use of this signature on all insurance submissions.

Permission to Disclose

I hereby give my permission to release my records, including all medical notes, test results, or x-rays to my spouse, parent, guardian, etc. Also, I give permission to be reminded of appointments by telephone and to leave a message on an answering machine or with an answering person. The permission will remain in force until denied.

Sign Here -______________________ Date-____________

Responsible Party Signature

Notice of Privacy Practices

I hereby acknowledge that I have received from Shore Podiatry a copy of its Notice of Privacy Practices. I understand that the notice sets forth my rights relating to the use and disclosure of my personal health information and explains how Shore Podiatry may use or disclose my personal health information with and without my authorization.

Sign Here- ______________________ Date -____________

Medicare Authorization

I request that the payment of authorized Medicare benefits be made either to me or on my behalf to Shore Podiatry for any services furnished me by those physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Sign Here- ______________________________ Date- ________________

SHORE PODIATRY

2424 Bridge Avenue Point Pleasant, NJ 08742
170 Morris Avenue Long Branch, NJ 07740

OFFICE FINANCIAL POLICY

This financial policy has been established to prevent misunderstandings. We like to acknowledge patients who take a responsible approach for paying their medical care.

Insurance: We must obtain a copy of your insurance card to provide proof of insurance. We will bill your insurance, but if payment is denied, You, the patient, will be responsible for payment for services rendered by the doctors on staff. **Knowing your insurance is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.**

Co-Pays & Deductibles: I understand that it is my responsibility to pay my co-pay on the day service is rendered. This arrangement is part of your contract with your insurance company. If you have a high deductible plan, after we receive notice from your insurance company, we will invoice you, the patient responsibility based on your deductible.

Appointments: If any appointment is broken or canceled without giving 24 hour notice, a charge of $25.00 will be applied to your account with potential discharge from the practice.

Medicaid: If you have medicaid as either a primary or secondary insurance: please be advised that if your medicaid coverage is not active on your day of service, you will be responsible for your copay and any balance after.

- I understand and agree to this term: Please initial: X___________

Assignment of Benefits/Non-Payment: I authorize payment of medical benefits to SHORE PODIATRY for services rendered to me. Any balance to an account is due within 30 days of receipt of the bill. If the account balance goes unpaid, a rebilling charge of $5.00 a month will be applied to your account. It is understood and agreed that in the event of any outstanding balance has to be referred to a collection agent or attorney for recovery, that the patient will be fully responsible for any costs, including, but not limited to attorney fees

For Patients that Need Insurance Referrals: If your insurance requires a referral from your primary care physician to a specialist, it is your responsibility to know this & obtain the referral prior to your visit. If the referral is not in place on the date of service, you will be asked to sign a waiver stating, if the referral is not received in a timely filing limit, you will be billed for the services rendered.

Non-Covered Services: Please be aware that some & perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by medicare or other insurances. You must pay for there services in full at the time of the visit. A from will need to be signed stating the services are not covered.

Self-pay: Payment in full is due at the time services are delivered

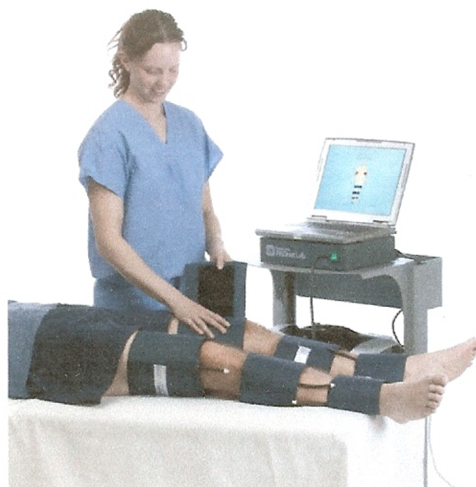
Returned Checks: Returned checks are subject to $30.00 service charge. In the event of a returned check your privilege to pay by check on future visits will be terminated. You will be subsequently expected to pay with cash or a credit card.

Please sign below to indicate that you have read and fully understand this policy.

Patient Name: X__________________________ **Date:** X_______________________

Signature: X__________________________________

Relationship if Legal Guardian: X_______________________________



Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:______________________________ Date:___________

Circle "Yes" or "No":

1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? (440.21)	Yes	No
2.	Do you experience any pain at rest in your lower leg(s) or feet? (440.22)	Yes	No
3.	Do you experience foot or toe pain that often disturbs your sleep? (440.22)	Yes	No
4.	Are your toes or feet pale, discolored, or bluish? (444.22)	Yes	No
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? (440.23)	Yes	No
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? (443.9)	Yes	No
7.	Have you suffered a severe injury to the leg(s) or feet? (904.8)	Yes	No
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? (440.24)	Yes	No

Patient Signature:______________________________