Dr. Alan J. Spector
Podiatric Medicine, Surgery, and Sports Medicine

Patient Information Form

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Sex: Male/Female Social Security Number: _____

Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _(___)_____ Work Phone: _(___)_____

Cell Phone: _(___)_____ Preferred Phone: Home/Work/Cell

E-Mail Address: _____

Ethnicity: _____ Preferred Language: _____ Race: _____

Marital Status: _____ Occupation: _____

Employer: _____ Employer Phone: _(___)_____

Employer Address: _____

How did you hear about us?

☐ Doctor's Office (Name): _____ ☐ Insurance Website

☐ Family/Friend (Name): _____ ☐ Google/Internet Search

☐ Facebook ☐ Other: _____

Name of Primary MD: _____

Town of Primary MD: _____ Phone: _(___)_____

Emergency Contact: _____ Relationship: _____

Phone: _(___)_____

Name of Pharmacy: _____

Town of Pharmacy: _____ Phone: _(___)_____

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Patient Name: _____ Today's Date: _____

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): _____

Please list (or provide a list) of current medications and dosages (or write none):

_____

_____

_____

Please list any surgery that you have had (or write none):

_____

_____

Do you currently smoke? Yes/No If yes, how many packs per day? ___

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

Do you drink alcoholic beverages? Yes/No

How many drinks do you consume in a day?___ in a week?___ in a year?___

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: _____

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Patient Name: _____ Today's Date: _____

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

- ☐ Anemia
- ☐ Angina
- ☐ Alzheimer's Dementia
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Cancer (type) _____
- ☐ Circulation Problems
- ☐ Depression
- ☐ Drug Use
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Emphysema/COPD
- ☐ Glaucoma
- ☐ Gout
- ☐ GERD (Reflux)
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hepatitis (Type A, B, C)
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Nervous Condition/Anxiety
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Rheumatoid Arthritis
- ☐ Stomach Ulcers
- ☐ Stroke/TIA
- ☐ Thyroid Disease (hypo/hyper)
- ☐ Tuberculosis
- ☐ Venereal Disease

Medical Conditions not listed above:

_____

Check any Allergies that apply:

- ☐ Adhesive/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Cortisone
- ☐ Iodine/Seafood
- ☐ Latex
- ☐ Narcotics
- ☐ Novocaine/Anesthetics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Others _____

Height: _____ **Weight**: _____ **Blood Pressure**: _____/_____

Check if there is a family history of the following conditions:

Hypertension: ☐ Mother ☐ Father ☐ Sister ☐ Brother

Diabetes: ☐ Mother ☐ Father ☐ Sister ☐ Brother

Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother

Reason for your visit: _____

Shore Podiatry Signature Sheet

Patient Name _____ Date of Birth _____

Certification and Consent

I, the undersigned 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 doctor 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 dependendent) 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.

Notice of Privacy Practices

I hereby acknowledge that I understand the office's 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. (A copy of the Notice of Privacy Practices is posted on the website or can be received from the front desk)

Signature _____ Date _____

Permission to Disclose

I hereby give my permission to release my records, including all medical notes, test results, or x-rays to the following person(s)

Person 1 _____ Relation to Patient _____

Person 2 _____ Relation to Patient _____

Signature _____ Date _____

☐ I give permission to be reminded of appointments by telephone and for these reminders to be left as messages on my answering machine or with whomever answers.

☐ I DO NOT give permission to be reminded of appointments by telephone and for these reminders to be left as messages on my answering machine or with whomever answers.

Signature _____ 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 rendered by Doctor Spector. 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 that 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.

Signature _____ Date _____

SHORE PODIATRY 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 form will need to be signed stating the services are not covered.

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

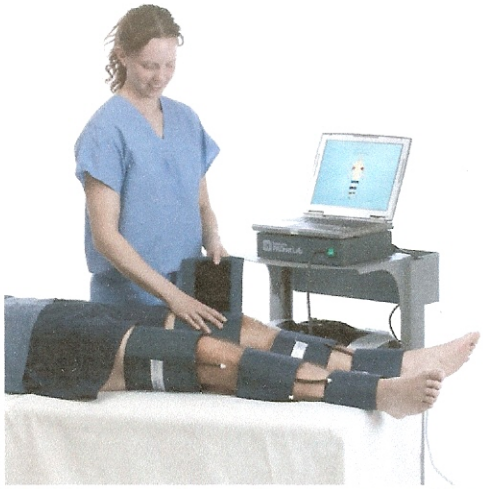
Returned Checks: Returned checks are subject to $30.00 service charge. In the event of a returned check your privilege to pay by check on future visits will be terminated. You will be subsequently expected to pay with cash or a credit card.

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:_____