South Jersey Foot and Ankle Specialists

REGISTRATION FORM

Patient's Name_____

Today's Date_____

Birth Date____/____/____ Age____ Male___ Female ___

Height: _____ Weight: _____ Shoe Size_____

Mailing Address: _____ City:_____ State:____ Zip:_____

Home Phone: _____ Cell:_____

Status: ___Minor ___ Single ___ Married ___ Divorced ___ Separated ___ Widow

Employer: _____

Occupation: _____

Work Phone:_____

Primary Language_____

Email:_____

Referred By: _____

Family Doctor: _____ Phone#_____

Pharmacy Name/Phone Number: _____

Insurance Name: _____

ID#_____ Group#_____

Insured's Name: _____

Social Security#_____

Insured's Employer: _____ Birth date: ___/___/____

Secondary Insurance: _____

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Emergency Contact:

_____Relation:_____

Phone: _____

Secondary Phone:_____

Reason for visit: _____

Please describe pain and its location: _____

When did the condition begin? _____Is it getting worse?_____

1) Is this an injury? ___Yes ___No If yes, when did it occur? ___/___/___

2) Check all of the following that apply:

Type of Pain __Burning __Tingling __Sharp __Dull Ache __Throbbing __Shooting __Stabbing __Numbness

When Painful __Upon Standing __During Walking __After Walking __During Sports __Worse with Activity __ Better as Activity Continues __Worse when standing __With Shoes __Without Shoes

__A.M. __P.M. __Lying in Bed __Always

3) How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", Please circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

4) Have you ever had an injury to the lower extremity? ___Yes ___No Explain

_____

MEDICATIONS

Medication	Dosage	How Often Taken?	What is it Taken for?

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ALLERGIES

☐NONE ☐OTHER _____

☐Penicillin ☐Sulfa ☐Iodine ☐Aspirin ☐Anesthetics ☐Latex

☐Codeine ☐Demerol ☐Darvocet ☐Cortisone ☐Environmental ☐Food

Type of Reactions:

_____

MEDICAL HISTORY

__ Diabetes __ Fibromyalgia __Tumors __Nerve Condition __Heart Problems __Gout

__Arthritis __Asthma/COPD __Skin Disorders __Tuberculosis __Anemia __Bursitis

__AIDS (HIV) __Lung Disease __Kidney Problems __Sickle Cell __Stroke __Hepatitis

__Osteoporosis __Bleeding Problems __Mental Disorders __Poor Circulation(PVD) __Heart Burn/Reflux

__High Blood Pressure __Joint Implants __Thyroid Disease __Rheumatic Fever

__High Cholesterol __Cancer Type _____ __Other_____

Diabetes; what is the name, phone number, and address of the doctor treating you for diabetes? _____

_____

When was your last visit? ___/___/____ What is your average blood sugar reading? _____

Last HbA1C:_____

Are you pregnant? ___Yes ____No How many months? _____

SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATIONS

FAMILY HISTORY

*Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Date of last physical Exam: ___/___/___

Do you smoke tobacco? ___Yes ___No

If Yes: # packs per day? ____ # cigarettes per day? _____ # of years Smoking? _____

If No: Did you ever smoke? ____ Yes ____ No If Yes: How long ago did you stop smoking?

Do you drink alcohol? ____Yes ____ No

If Yes: How much? ____ Social____ Occasional ____ Frequent

Recreational drug use: ____Yes ____No

If Yes: What substance and how often? _____

REVIEW OF SYSTEMS *If you are experiencing any of the following please **CIRCLE**:

Constitutional: Chills, Dehydration, Fever, Headache, Night Sweats.

CV: Swelling, Chest Pain, Calf Cramping, Claudication, Elevated BP,Heart Palpitations, Heart Murmur, Shortness of Breath.

Endocrine: Cuts take longer to heal, Dry Skin, Extreme Thirst

ENMT: Cough, Chronic Difficulty with swallowing, Sinus Congestion, Symptoms involving ear, nose, mouth, or throat.

EYES: Blurred vision, Cataract, Glasses, Glaucoma, Loss of vision, Macular Degeneration, Trauma to the Eyes.

GU: Kidney Dialysis, Burning with Urination, Blood in urine, Urinary frequency.

Immunologic: Gouty Attack, Environmental Allergies, Asthma Attack Recently, Allergic of Immunologic symptoms, Arthritic Flare-up.

Integumentary: Athletes foot, Blisters, Burning of Skin, Dry Scaly Skin, Hair Loss, Itchy Skin, Tingling Sensation.

Lymphatic: Anemia, Ankle Edema, Bleeding Tendency, Bruise Easily, Leg Swelling.

MSK: Back Pain, Foot Pain, Heel Pain, Leg Cramps.

Neurological: Burning Foot Pain, Hypersensitivity, Neuropathy, Numbness, Tingling.

Psychiatric: Addiction to Alcohol, Depression, Paranoia, Mental Status Changes, Psychiatric or Emotional Difficulties.

Respiratory: Asthma, Breathing Difficulties, COPD, Emphysema, and Sleep Apnea.

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.**
- **Obtain payment for third-party payers.**
- **Conduct normal healthcare operation such as quality assessments and physician certifications**

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I have been given the right to review such notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change it's Notice of Privacy Practices from time to time; and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand that you are not required to agree to my requested restrictions. However, if you agree; you are bound to abide by such restrictions.

I give my permission for this office to leave a message on my answering machine and/or with a family member.

I understand that I may revoke this consent in writing at any time; except to the extent that you have taken action relying on this consent.

Patient/Guardian Name: _____

Signature of Patient/Guardian: _____Date:_____

Relationship to Patient: _____

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FINANCIAL POLICY

We accept assignment of insurance benefits. However, we require that all co-pays and non-covered services be paid at time of service. We will bill your insurance company. Your insurance policy is a contract between you and your insurance company. We are not part of the contract. If your insurance company does not pay your account in full the balance will be your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and other medical insurances.

I understand and agree to this policy. I understand and agree to the consent form. The information I provided above is true and to the best of my knowledge.

Patient/Guardian Name: _____

Signature of Patient/Guardian: _____Date:_____

Relationship to Patient: _____