PODIATRY ASSOCIATES OF NEW JERSEY, LLC
309 ROCK AVENUE
GREEN BROOK, NEW JERSEY 08812

PATIENT INFORMATION SHEET

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

MARITAL STATUS: S M D W SEP SOCIAL SECURITY:_____ SEX: M F

PRIMARY LANGUAGE:_____ ETHNICITY: ARE YOU HISPANIC OR LATINO

HOME PHONE:_____ CELL PHONE:_____

WORK PHONE:_____ OCCUPATION:_____

EMPLOYER NAME AND ADDRESS:_____

PRIMARY CARE PHYSICIAN NAME AND NUMBER:_____

REFERRING (IF DIFFERENT FROM ABOVE) :_____

EMAIL:_____DO NOT HAVE ONE_____

PHARMACY NAME/CITY/PHONE NUMBER:_____

EMERGENCY CONTACT:_____PHONE:_____RELATIONSHIP:_____

WHAT IS THE MAIN REASON FOR TODAYS VISIT:_____

INSURANCE INFORMATION

IS YOUR VISIT TODAY: EMPLOYMENT RELATED Y/N AUTO ACCIDENT RELATED Y/N

PRIMARY INSURANCE:_____ POLICY HOLDER: SELF SPOUSE DEPENDENT

POLICY#:_____GROUP:_____

POLICYHOLDER NAME AND DATE OF BIRTH:_____

SECONDARY INSURANCE:_____ POLICY HOLDER: SELF SPOUSE DEPENDENT

POLICY#:_____GROUP:_____

POLICYHOLDER NAME AND DATE OF BIRTH:_____

I REQUEST THAT PAYMENT OF ALL AUTHORIZATED MEDICARE BENEFITS, ALL COMMERCIAL INSURANCE BENEFITS, MEDIGAP BENEFITS BE MADE ON MY BEHAVE TO: PODIARTY ASSOCIATES OF NEW JERSEY, LLC FOR ANY AND ALL SERVICES RENDERED TO ME BY SAME. I HEAREBY AUTHORIZE RELEASE OF INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES TO FILEA CLAIM WITH MY INSURANCECOMPANY AND ASSIGN BENEFITS, OTHERWISE PAYABLE TO ME TO: PODIARTY ASSOCIATES OF NEW JERSEY, LLC. I AM AWARE AS A MEDICARE PATIENT . THE OFFICE ACCEPTS THE 80% THAT MEDICARE ALLOWS AND I AM RESPONSIBLE FOR THE 20% THAT MEDICARE DOES NOT PAY IN ADDITION TO THE YEARLY DEDUCTIBLE.

PATIENT SIGNATURE: _____ DATE:_____

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PATIENT: _____ DATE:_____

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING:

VISION Y/N EXPLAIN:_____

SLEEP/FATIGUE Y/N EXPLAIN:_____

SPEECH Y/N EXPLAIN:_____

SWALLOWING Y/N EXPLAIN:_____

APPETITE/WEIGHT Y/N EXPLAIN:_____

BLADDER FUNCTIION Y/N EXPLAIN:_____

BOWEL FUNCTION Y/N EXPLAIN:_____

GAIT/WALKING Y/N EXPLAIN:_____

BLEEDING DISORDERS Y/N EXPLAIN:_____

PAIN Y/N EXPLAIN:_____

MOOD Y/N EXPLAIN:_____

BREATHING Y/N EXPLAIN:_____

DIABETES/THYROID Y/N EXPLAIN:_____

DO YOU SMOKE Y/N HOW MUCH:_____

DO YOU DRINK ALCOHOL Y/N HOW MUCH_____

HEIGHT:_____ WEIGHT:_____

LIST OF MEDICATIONS AND DOSAGES:_____

_____

_____

DO YOU HAVE **ALLERGIES** TO MEDICATION/SUBSTANCES/FOOD Y/N _____

MEDICAL PROBLEMS SURGERIES/HOSPITALIZATIONS

_____ _____

_____ _____

HAS ANYONE IN YOUR **FAMILY** HAVE OR SUFFER FROM THE FOLLOWING? M=MOTHER F=FATHERS=SISTER B=BROTHER

____CANCER _____STROKE _____DIABETES _____HEART DISEASE _____HIGH BLOOD PRESSURE

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ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

PATIENT NAME (please print) DATE

_____

SIGNATURE

RELATIONSHIP TO PATIENT:

SELF:_____

PARENT:_____

AUTHORIZED REPRESENTATIVE:_____

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MEDICAL INSURANCE AUTHORIZATION

SIGNATURE ON FILE

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.

I AUTHORIZE RELEASE OF NECESSARY INFORMATION TO ALL MY INSURANCE CARRIERS

I AUTHORIZE MY DOCTOR'S STAFF TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIER.

I AUTHORIZE PAYMENT FROM MY INSURANCE CARRIER DIRECTLY TO MY DOCTOR.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

PATIENT'S NAME:_____

SIGNATURE:_____

DATE:_____