DR. KENNETH DONOVAN, D.P.M.

Diplomate of American Board in Foot and Ankle Surgery

9 Mount Bethel Road, Suite 209, Warren, NJ 07059
200 South Orange Ave, Suite 107, Livingston, NJ 07039
104 Commons Way, Suite A, Toms River, NJ 08755
Phone: (908) 605-0799
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PATIENT INFORMATION SHEET

Date: _____ Last Name: _____ First Name: _____ Middle Initial: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Birth Date: _____ Age: _____

Street: _____ City _____ State: _____ Zip _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____ Occupation: _____

Preferred Method of Communication: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Emergency Contact: _____ Phone: (_____) _____ Relationship: _____

Pharmacy Name/Town: _____ Pharmacy Phone: (_____) _____

Primary Care Physician: _____ Physician Phone: (_____) _____

How did you find us? ☐ Google ☐ Facebook ☐ Zocdoc ☐ Family Doctor ☐ Referral ☐ Mailer ☐ Hospital ☐ Seminar ☐ Insurance

Who can we thank for your referral? _____

INSURANCE INFORMATION: (no need to fill out if copies of cards made)

Primary Insurance: _____ ID# _____ Group# _____

Secondary Insurance: _____ ID# _____ Group# _____

MEDICAL HISTORY: Weight _____ lbs Height _____ Shoe Size: _____ Most Worn Shoe Type? _____

Describe Foot/Ankle Problem _____

_____ ☐ Right Side ☐ Left Side

Ever Been to a Foot Doctor Before? ☐ Yes ☐ No For What? _____

Do you have, or have you ever been treated for:

☐ GERD	☐ Heart Attack	☐ Arthritis	☐ Epilepsy
☐ Stomach Ulcer	☐ High Blood Pressure	☐ Osteoprosis	☐ Fibromyalgia/RSD
☐ Liver Disease	☐ High Cholesterol	☐ Gout	☐ Stroke
☐ Hepatitis	☐ Arrhythmia	☐ Poor Circulation	☐ Hearing/Ear Disorder
☐ AIDS/HIV	☐ Valvular Heart Dz	☐ Kidney Disease	☐ Glaucoma
☐ Hypothyroid	☐ Asthma	☐ Anemia	☐ Nerve Disorder
☐ Hyperthyroid	☐ Lung Disease	☐ Psychiatric Disorder	☐ Sciatica
☐ Diabetes	☐ Rheumatoid Athritis	☐ Alzheimers	☐ Cancer

Other Past Medical History Not Listed: _____

Past Surgical History: _____

Allergies to Medications: _____

Current Medications (Doses Not Necessary): _____

Family History: ☐ Diabetes ☐ Heart Disease ☐ Poor Circulation ☐ Blood Clots ☐ Foot Problems ☐ Stroke ☐ Melanoma

Social History: Smoking Status: ☐ Former ☐ Current ☐ Never Drink Alcohol Daily? ☐ Yes ☐ No _____ Amount?

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CONSENT FOR EVALUATION/TREATMENT and HIPAA ACKNOWLEDGEMENT

You have the right to be informed about your condition, including the testing that may be recommended to diagnose the condition, the medical and surgical treatments that may be recommended to treat the condition, and the benefits and risks of any recommended treatment options. At this point in your care, nothing specific has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify any condition that may be present, as well as perform any in-office treatments/procedures that may be recommended to treat the condition.

By signing below, you are indicating that (1) you consent to evaluation and in-office treatment at this office or any satellite office under common ownership, and (2) this consent is continuing in nature for future visits at this office or any satellite office. This consent will remain in effect until it is revoked in writing by you. You have the right to discontinue services at any time. If you have concerns regarding anything recommended, we encourage you to ask questions.

I voluntarily request that a physician performs a medical examination, and reasonable and necessary testing and in-office treatment for the condition which has led me to seek care at this practice. I understand that if more invasive testing or treatment procedures are recommended, I will be asked to read and sign additional consent forms.

In addition to the above consent for treatment, I understand that, under the Health Insurance Portability & 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: 1) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly. 2) Obtain payment from third-party payers. 3) Conduct normal healthcare operations such as quality assessments and physician certifications. I have read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (and can be provided a copy upon request)

I certify that I have read and fully understand the above statements, and consent fully and voluntarily to its contents.

Patient Name: _____ Signature: _____ Date: _____

Patient Rep: (if patient is minor): _____ Relationship: _____

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my insurance companies
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance company
- I authorize direct payment to my doctor
- I authorize my medical records to be released to my primary care doctor
- I authorize permission for any appeals done on my behalf to my insurance company
- I understand that I am fully responsible for my bill if denied by my insurance company
- I understand that I am fully responsible for obtaining any referrals required by my insurance company and being aware that all referrals are made out appropriately to my doctor

Patient Name: _____ Signature: _____ Date: _____

Patient Rep: (if patient is minor): _____ Relationship: _____