# ADVANCED CARE FOOT AND ANKLE
# TOMS RIVER PODIATRIST

9 Mt Bethel Rd, #209
Warren, NJ 07059
908-605-0799

200 S. Orange Ave, Ste 107
Livingston, NJ 07039
908-605-0799

104 Commons Way, Bldg A
Toms River, NJ 08755
732-349-1123

## PATIENT INFORMATION SHEET

Last Name: ______________________________ First Name (Legal): ______________________MI: ____

Email: ______________________________________ Preferred Name: _________________________

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

Emergency Contact: _______________________Phone: ________________Relationship: ____________

Pharmacy Name/Town:______________________________ Pharmacy Phone ______________________

Primary Care Physician/Town:______________________________ Occupation:______________________

How did you find us? ☐ Online ☐ Friend ☐ Doctor Referral ☐ Mailer ☐ Hospital ☐ Seminar ☐ Insurance ☐ Sign/Building

Who can we thank for your referral?________________________________________________________

Street/Apt: _______________________________ City: _________________State:_____ Zip_________

Home Phone: ________________ Cell Phone: ________________ ☐ Patient Cell ☐ Parent Cell ☐ Caregiver

**INSURANCE INFORMATION:**

Primary Insurance: __________________________ ID#_______________________________________

Insurance Holder Name / Date of Birth (if different than patient) __________________________________

Secondary Insurance: __________________________ID#_____________________________________

**MEDICAL HISTORY:** Weight ______ lbs Height ________ Shoe Size: ________

**Describe Foot/Ankle Problem: ☐ Right ☐ Left** _______________________________________________

_____________________________________________________________________________

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

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

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

**Social History**: Smoking Status: ☐ Former ☐ Current ☐ Never Alcohol Consumption: ☐ Daily ☐ Occasionally ☐ Never

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## CONSENT FOR EVALUATION/TREATMENT and HIPAA ACKNOWLEDGEMENT

**Initials: ______** I consent to evaluation and in-office treatment at this office or any satellite office under common ownership. I consent that the 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

**Initials: ______** You have the right to be informed about your condition, including recommended diagnostic tests, medical or surgical treatments, and the benefits and risks of any options. At this time, no specific treatments have been recommended. This consent is to authorize evaluation and in-office treatments or procedures as needed to identify and address any condition.

**Initials: ______** I understand that my health history 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 my treatment directly and indirectly. I understand that my health history can and will be used to: Obtain payment from third-party payers. I understand that my health history can and will be used to: Conduct normal healthcare operations such as quality assessments and physician certifications.

**Initials: ______** You acknowledge receipt of the Notice of Privacy Practices, which provides further details on the use and disclosure of your health information, and can request a copy at any time.

### OFFICE FINACIAL POLICY AND NO SHOW/CANCELLATION POLICY

**Initials: ______**Our office values punctuality and strives to see patients on time without overbooking. To maintain this standard, it is essential that patients arrive promptly for their appointments. Therefore, a $25 "No-Show/Late Cancellation" fee will be charged to patients who miss their appointment without notifying the office at least 12 hours in advance. This fee must be paid before scheduling future appointments. I acknowledge and accept this policy.

**Initials: ______**If your insurance plan requires a copay, it is due at the time of your visit. For patients whose insurance plans include high deductibles or coinsurance, a pre-payment toward your remaining deductible will be required at the time of service. This allows us to process your claim more efficiently and reduce the risk of unexpected balances later. I acknowledge and accept this policy.

**Initials: ______**Please note that a 2.6% processing fee will be added to all payments made by credit or debit card. This fee is collected by our office, but is passed directly to the credit card companies to cover our transaction costs. We accept cash or check for those wishing to avoid additional charges. I acknowledge and accept this policy.

**Initials: ______**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

### SIGNATURE ON FILE

I certify that I have read and fully understand the above (8) statements, and consent fully and voluntarily to its contents

Patient Name: ______________________________ Signature: ______________________ Date: ________________
(if minor parent/guardian signs on their behalf) ☐(Typed signature accepted as equivalent to full written signature)