

**Central Jersey Ankle & Foot Care Specialists, PC**  
**Division of New Jersey Podiatric Physicians & Surgeons Group. LLC**

**Patient Information Form** (please print clearly)

Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Age: \_\_\_\_ Sex: *M F* Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**PRIMARY** Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **SECONDARY** Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email address: \_\_\_\_\_ (will not be shared)

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Date last seen:** \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who is responsible for payment? \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City / State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Insurance information**

**Primary** insurance Company: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

ID#: \_\_\_\_\_ Group # : \_\_\_\_\_

Address: \_\_\_\_\_ City / State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Secondary** insurance Company: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

ID#: \_\_\_\_\_ Group # : \_\_\_\_\_

Address: \_\_\_\_\_ City / State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Medications**

(Please list ALL medications you are currently taking (include prescriptions, over the counter meds and herbal supplements))

Medications Name:	Dose:	How often do you take?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Surgery,** Please list ALL prior surgeries:

Type of Surgery:	Date:
_____	_____
_____	_____
_____	_____

**Hospitalizations,** please list ALL prior hospitalizations (other than Surgeries)

Reason for hospitalization:	Date:
_____	_____
_____	_____
_____	_____

**Social History**

- Marital Status:**  Single  Married  Partnered  Separated  Divorced  Widowed
- Used of Alcohol:**  Never  No longer use  History of alcohol abuse  Current use – Type: \_\_\_\_\_  
 Rare  Occasional  Moderate  Daily
- Use of tobacco:**  Never  Quit – how long? \_\_\_\_\_ Smoke \_\_\_\_ pks/day for \_\_\_\_ years
- Use of recreational drugs:**  Never  Quit – how long? \_\_\_\_\_  
Current use – Type: \_\_\_\_\_  Rare  Occasional  Moderate  Daily

**Family History:**

- Do you have a family history of:**  Diabetes: Type 1 or 2  Cancer  Heart Disease  Stroke  
 High Blood Pressure  Coronary Artery Disease  Bleeding Disorder  Rheumatoid Arthritis  
Other \_\_\_\_\_

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**Your Medical History**

Allergies:  Medications \_\_\_\_\_  
 Anesthesia \_\_\_\_\_  Foods \_\_\_\_\_  
 Tape  Latex  Shellfish  Iodine  Other \_\_\_\_\_  
 None Known

Reaction: \_\_\_\_\_

**Have you ever had any of the following?**

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+ / AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/ Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or 2	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Other: \_\_\_\_\_

**Current Problem**

**What specific problem brings you to our office today?** \_\_\_\_\_

**Which foot (please circle one):**     **RIGHT**     **LEFT**     **BOTH**

**How long ago did this problem first start?** \_\_\_\_\_ **DAYS / WEEKS / MONTHS / YEARS**

**Did your pain or problem:**      Begin all of a sudden      Gradually develop over time

**How would you describe your pain or symptoms?**

No Pain      Sharp      Dull      Aching      Burning      Radiating      Itching      Stabbing

Other \_\_\_\_\_

**Since the time your pain or problem begun, has it:**      Stayed the same      Become worse      Improved

**What makes your pain or problem feel worse:**      Walking      Standing      Daily Activities      Resting

Dress shoes      High heels      Flat shoes      Any closed to shoe      Running      Other \_\_\_\_\_

**What makes your pain, or problem feel better:** \_\_\_\_\_

**What treatments have you had for this problem:** \_\_\_\_\_

**Was this problem caused by an injury?**     YES     NO     (describe) \_\_\_\_\_

**Work Related?**     YES     NO

**E-Prescribing Consent**

E-Prescribing is defined by a physician’s ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act 2003 listed standards that have to be included in an E- Prescribing program. These include (1) Formulary and benefit transactions, which gives the prescriber information about which drugs are covered by a drug benefit plan; (2) medication history transactions, which provide the physician with information about medications the patient is already taking to minimize adverse drug events.

I authorize **CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC Division of NJPPSG** to view my external prescription history vis electronic E- Prescribing services. I understand that prescription history from multiple, other unaffiliated, providers, insurance companies, pharmacies, and pharmacy benefits managers may be viewable by the providers and staff of **CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC Division of NJPPSG**, and it may include prescriptions back in time for several years and my included prescriptions to treat HIV, substance abuse, and psychiatric conditions. If applicable, I understand that my prescription history will become part of my record at this practice. Understanding all of the above, I hereby provide informed consent to **CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC Division of NJPPSG**, to enroll me in the E- Prescribing program. This consent will remain enforced until revoked or changed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent/Legal Guardian Signature

I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I give permission to the doctors at **CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC Division of NJPPSG** to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and / or treatment of my condition.

Patients / minors under the age of 18, will not be treated without a parent of legal guardian present. If another family member, caretaker or friend, over the age of 18 will be present, written consent from the parent/legal guardian stating as such must be presented at the time of the appointment. Thank You.

\_\_\_\_\_  
Print name of patient

\_\_\_\_\_  
print parent/legal guardian

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date



**Financial Policy for Central Jersey Ankle & Foot Care Specialists, PC**

*Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.*

**INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan, we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

**MEDICARE:** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

**SECONDARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

**COPAYMENTS & DEDUCTIBLES:** All copayments and deductibles must be paid at the time of service; this agreement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

**SELF PAY:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers, you are responsible for payment of these services.

**REFERRALS/AUTHORIZATIONS:** We are *required* to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you *must* have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary care physician and keeping track of your visits is YOUR responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled

**CLAIM SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, your insurance benefit is a contract between you and your insurance company.

**PATIENT BILLING:** You will be sent up to three notices for your financial responsibility (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections with interest accruing on balance. It is also your responsibility to pay for the interest accrued if sent to collection, please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: **cash, check, Visa, Mastercard, Amex, and Discover**. An additional \$25.00 will be added to your statement of the check is returned for insufficient funds. If your insurance company should happen to send payment to you, the patient, we expect that you will forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to **CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC Division of NJPPSG** for medical services provided. I agree to pay **CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC Division of NJPPSG** any balance unpaid by my insurance carrier for myself or the below named person.

**ASSIGNMENT OF BENEFITS**

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC Division of NJPPSG** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits, I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or to release all information necessary to secure payment benefits, I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient / Parent / Legal Guardian

\_\_\_\_\_  
Financially Responsible Party (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date