WELCOME TO OUR OFFICE
PLEASE PRINT THE FOLLOWING INFORMATION
THANK YOU

DATE: _____/_____/_____

PATIENT NAME: ____
LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER: ______/_____/______ **D.O.B:** _____/_____/______

STREET ADDRESS: ____

CITY: ______________________ **STATE:** ______ **ZIP CODE:** ___________

SEX: ☐ Male ☐ Female **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY LANGUAGE SPOKEN IN THE HOME: _________________________

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic nor Latino

RACE: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian

☐ Alaska Native ☐ Native Hawaiian ☐ Pacific Islander **Other:**__________

PHONE NUMBERS:
HOME ______/______/________
WORK ______/______/________
CELL ______/______/________

EMAIL ADDRESS:____

EMERGENCY CONTACT NAME & PHONE # _________________________________

WORK STATUS: ☐ Full time ☐ Part Time ☐ Retired ☐ Student

EMPLOYER: ____

PRIMARY CARE PHYSICIAN: _____________________________________

WHO REFERRED YOU TO OUR OFFICE: ____________________________

NAME OF PRIMARY INSURANCE: ____________________________________

NAME OF SECONDARY INSURANCE: _________________________________

POLICY HOLDER NAME: ________________________________
(IF NOT YOURS)

POLICY HOLDER DATE OF BIRTH: ______/______/______

RELATIONSHIP TO POLICY HOLDER__________________________

NEXT PAGE PLEASE

Richard L. Corbin, DPM, FACFAS
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

Matthew F. Wachtler, DPM, AACFAS
Associate, American College of Foot & Ankle Surgeons

Samantha L. Sheppard, DPM, AACFAS
Associate, American College of Foot & Ankle Surgeons

Patient Name: ______________________________________ **Today's Date:** ______________________

Reason for today's visit: ____

Allergies to medication: ____

Current medications: ____

____

____

Past Medical History, Medical Conditions:

____

Past Surgical History: ____

Family Medical History of Cancer, Heart Disease, Diabetes or other medical conditions

Father: ____

Mother: ____

Brother: ____

Sister: ____

Do you smoke cigarettes (circle): Yes No

- How many packs per day: __________________ For how many years: _____________

Do you drink alcohol (circle): Never Occasionally Daily

Patient Signature: ____

1250 Park Avenue, Plainfield, NJ 07060 P: 908-755-0707 F: 908-755-9204
2253 South Avenue, Suite 1, Scotch Plains, NJ 07076 P: 908-233-1903 F: 908-233-1909
619 Morris Avenue, Springfield, NJ 07081 P: 973-379-9333 F: 973-218-1668

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ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided an opportunity to read (if I chose to) a copy of the notice of Privacy Practices and understood the notice.

_______________________________ ___________________

Patient Name (please print) Date

____

Parent of Authorized Representative (if applicable)

____

Signature

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INSURANCE

Although I have health insurance, I am aware that this is no guarantee of payment. If my insurance company denies payment, I understand that I am ultimately responsible for this bill.

If my insurance requires a referral, it is solely my responsibility to obtain the referral before my office visit. If I do not obtain the referral prior to the visit, payment for the visit is my responsibility.

I am responsible to notify the office of any and all changes in my health insurance and present updated cards in coordination. If I do not provide accurate information, I am responsible for payment of office visit.

____
Print Patient Name

____
Patient Signature

____
Date

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HIPPA Consent Form

I, ______________________, understand that under the Health Portability and Accountability Act 1996 (HIPAA) I have certain rights to privacy regarding my health information. I also understand that Garden State foot & Ankle Specialist originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for future care and treatment at Garden State foot & Ankle Specialist.
I understand that this information can be used as:

- A basis for planning my care and treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- A means of communication among the many health professionals who contribute to my care.
- A means by which a third-party payer can verify that services billed were actually provided and obtain payment from third party payers.
- A tool for routine healthcare operations such as assessing quality and receiving the competence of healthcare professionals.

I prefer to have notification of my healthcare information by the following methods. Please check all applicable:
________ Home telephone
________ If I am not available, you may leave a message with a family member
________ Detailed message on answering machine
________ Work phone with direct contact only
________ Cell phone

My health information may also be discussed with the following people upon their request:

Name:	Relationship:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

____________________________ ____________________
Patient Signature Date

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