

Dr. Morris Morin, DPM
Dr. Elena Blanco, DPM
125 Prospect Ave
Hackensack, NJ 07601

Date: _____

Patient Information

Last name: _____ First name: _____ M.I.: _____
Street address: _____ Apt: _____
City: _____ State: _____ Zip code: _____
Home phone #: _____ Cell phone #: _____
Email address: _____
Race: _____ Preferred Language: _____
Sex: Male Female Age: _____ Birthdate: _____ SSN: _____
Marital status: Married Widowed Single Minor Separated Divorce
Family physician: _____ Last visit date: _____
** What is the chief complaint for which you came to be treated? (Include foot, ankle, knee,
thigh, and hip complaints) _____

Insurance Information

****Please provide insurance cards & photo ID to receptionist****

Primary Insurance: _____
Member ID: _____ Group #: _____
Subscriber's Name: _____ Date of Birth: _____
Patient's relationship to subscriber: Self Spouse Child Other _____
Secondary Insurance (if applicable): _____
Member ID: _____ Group #: _____
Subscriber's Name: _____ Date of Birth: _____
Patient's relationship to subscriber: Self Spouse Child Other _____

In Case of Emergency

Name: _____ Phone #: _____
Relationship: _____

Pharmacy/Medications

Pharmacy: _____ Town, State: _____
Medications: _____

Allergies

<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Demerol	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Anticoagulant/ Therapy	<input type="checkbox"/> Iodine	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Novocaine	<input type="checkbox"/> Other: _____

Medical History (Check ONLY that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Corns and Calluses | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Allergies to Medicine/Drugs | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Numbness in Feet or Legs |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fainting | <input type="checkbox"/> Plantar Warts |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Flat feet | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valves/Joints | <input type="checkbox"/> Foot or Leg Cramps | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Swelling in Ankles or Feet |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tired Feet |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Ingrown Toenails | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Weight Loss, unexplained |

Surgical History

*Please list all surgeries you have had _____

Social History

Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone Number (_____) _____
Cigarette/Tobacco Use: Yes No
If yes, how many cigarettes do you smoke per day? _____
Who may we thank for referring you? _____

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian, or Personal Representative

Date

FINANCIAL POLICY for DR. BLANCO

Financial Policy

Thank you for choosing Dr. Elena Blanco as your foot care provider. We are committed to providing you with quality and affordable healthcare. Please review the following office payment policy and feel free to address any questions that you may have with our office staff. Your acceptance of this agreement requires that you kindly sign in the space provided below. A copy will be provided to you, upon request.

1. **Insurance.** We participate with most insurance plans. If you are not insured by a plan we participate with, payment in full will be expected at every visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. Co-insurance and Deductibles are your financial responsibility, once the insurance has paid their part of the claim. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us to uphold the law by paying your co-payment at every visit.
3. **Non-covered services.** Please be aware that some-- and perhaps all-- of the services you receive may not be covered or not considered reasonable or medically necessary by Medicare or other insurers. Therefore, it is your responsibility to check with your insurance company regarding your coverage, or you will be responsible for any balance not covered by your insurance company.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card.
5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you to receive your maximum benefits.
6. **Referrals.** It is your responsibility to obtain the proper referral from your Primary Care Physician, if your insurance requires it. Patients presenting to our office without a valid referral will be asked to pay in full. The payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained.
7. **Claims Submission.** We will submit your claims and assist you in any way that we can reasonably help to 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 whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
8. **Nonpayment.** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of your healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted, unless otherwise approved by our billing department. Please be aware that if a balance remains unpaid, that we will take legal action and the doctor is at liberty to send you a written notification of his discharge of care. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During the 30-day period, our physician will only treat you on an emergency basis.
9. **Missed appointments.** Our policy requires 24 hour advance notice when canceling an appointment. A \$50.00 fee may be incurred for frequent cancellations.
10. **Fees.** Our fees are representative of the usual and customary charges for our area.

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

<input checked="" type="checkbox"/>	
SIGNATURE OF PATIENT PARENT OR AUTHORIZED REPRESENTATIVE	DATE

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**MEDICAL INFORMATION RELEASE FORM
(HIPPA RELEASE FORM)**

Patient Name: _____ **Date of Birth:** _____

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

- Spouse: _____
- Child(ren): _____
- Other: _____
- Information is not to be released to anyone

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient name: _____ **Date of Birth:** _____
Signature: _____ **Date:** _____

TEXT MESSAGING AND EMAIL CONSENT

Our practice has a mobile text messaging and email communication service. This service will be used for phone calls, text, and email reminders to patients regarding upcoming appointments. We always strive to maintain the confidentiality of your information and will continue to do so while using this system. To help us do this, it is **important that you let us know if you change your mobile number or email address in the future.**

If you give us consent to communicate with you by mobile text messaging and/or email as outlined above, please fill in your details below. **If you decide you no longer wish to receive messages through this service, please inform us.**

Patient name: _____
Date of birth: _____
Mobile number: _____
Email address: _____

Opt out of electronic communication service.