



Woodbury Foot and Ankle Center
 Heights Plaza
 722 Mantua Pike, Suite 8
 Woodbury Heights, NJ 08097
 (856) 384-1333 Fax (856) 384-1297
woodburyfootandankle@gmail.com

Welcome to our office! Please fill out the following 5 pages. Thank you!

Patient's Name: _____

Gender: Male _____ Female _____

SS#: _____ - _____ - _____

Date of Birth: ____ / ____ / ____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____

Primary Doctor: _____

Primary Doctor's Phone: (____) _____ Date Last Seen: ____ / ____ / ____

Primary language _____ Race: _____ Ethnicity _____

How did you hear about our office? _____

Emergency Contact's Name: _____

Emergency Contact's Phone Number: (____) _____

Marital Status: M S DP W D

Are you currently a student? NO Full Time Part Time

Are you currently working? NO Full Time Part Time

Occupation: _____

Employer: _____

Employer's Address: _____

Insurance Information:

Insurance Company: _____

Do you need referrals? YES NO

Primary Policy Holder's Name: _____

Policy Holder's D.O.B ____ / ____ / ____ SS# _____ - _____ - _____

Policy Holder's Relationship to Patient: _____

Secondary Insurance: _____

Policy Holder's Name: _____ D.O.B ____ / ____ / ____

Please describe the reason for your visit today: _____

How long has this been bothering you? _____

Is your problem the result of trauma or injury? If so, please explain: _____

What activities aggravate your condition? _____

Is this condition worsening? Y N Is it constant? Y N

Have you received treatment for this condition from another physician or healthcare provider? If yes, who treated you and what was done? _____

Did this treatment give you relief? If yes, for how long? _____

What tests were performed and where? _____

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 TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS: _____								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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 SYMPTOM?

NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, 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 TOE SHOE
 RUNNING OTHER _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES NO (DESCRIBE) _____

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETIS: TYPE 1 OR TYPE 2 CANCER HEART DISEASE
 HIGH BLOOD PRESSURE STROKE CORONARY ARTERY DISEASE BLEEDING DISORDER
 RHEUMATOID ARTHRITIS OTHER _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of Notice of Privacy Practices and that I have read for had the opportunity to read and understand the Notice of Privacy Practices and agree to its terms

Name of Patient

Date of Birth

Signature of Patient/Parent/Guardian

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physican Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Last four digits SSN (required) _____
Print Name: _____ Last four digits SSN (required) _____
Print Name: _____ Last four digits SSN (required) _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

Written Communication Address:

OK to leave message with detailed information
 Leave message with call back numbers only

OK to mail address listed above
Email me at: _____

Work Telephone Number:

Fax Number:

OK to leave message with detailed information
 Leave message with call back numbers only

OK to mail address listed above
Email me at: _____

Other: _____

Name of Patient (Printed)
Patient/Parent/Guardian

Signature of

Witness Signature

Date

E-PRESCRIBING CONSENT

E-PRESCRIBING IS DEFINED BY A PHYSICIANS 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. EPRESCRIBING 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 PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE ADVERSE DRUG EVENTS. I AUTHORIZE **WOODBURY FOOT AND ANKLE CENTER**, TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E-PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF **WOODBURY FOOT AND ANKLE CENTER**, AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE 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 HERBY PROVIDE INFORMED CONSENT TO **WOODBURY FOOT AND ANKLE CENTER** TO ENROLL ME IN THE E-PRESCRIBE 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 **WOODBURY FOOT AND ANKLE CENTER** 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.

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARE TAKER 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.

NAME OF PATIENT _____

PATIENT SIGNATURE _____

NAME OF PARENT/LEGAL GUARDIAN _____

PARENT/LEGAL GUARDIAN SIGNATURE _____

FINANCIAL POLICY

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. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding 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 AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment 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 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 (co-insurance, 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 collections. 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, Credit/Debit Cards, Checks. An additional \$25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to **WOODBURY FOOT AND ANKLE CENTER** for medical services provided. I agree to pay **WOODBURY FOOT AND ANKLE CENTER** 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 **WOODBURY FOOT AND ANKLE CENTER** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, 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 requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Pharmacy



Patients Name

Pharmacy Name

Phone
