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

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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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Name ________________________ Medicare #_____________________________

"I request that payment of authorized Medicare benefits be made on my behalf to the name of provider of service and (or) supplier for any service furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

____________________________ __________________
Beneficiary Signature Date

Name ________________________ Medicare #_____________________________

Secondary Policy #________________________

"I request that payment of authorized secondary benefits be made on my behalf to the name of provider of service and (or) supplier for any service furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the secondary insurer and its agents any information needed to determine these benefits or the benefits payable for related services."

____________________________ __________________
Beneficiary Signature Date

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Medicare has specific rules covering payment for mycotic (fungal) toenails. In order for Medicare to cover the debridement (cutting) of nails, one must have pain associated with the condition and/or have a medical condition such as Diabetes or poor circulation. If I have been told by my doctor that I do not have a qualifying condition, I must pay the doctor for the services today and I will not be reimbursed by Medicare. The following best describes my situation. However, if I was seen by my doctor within 61 days for mycotic nail treatment, I must pay for that service and Medicare will not reimburse me.

□ I have marked limitation of ambulation (walking) when the infected toenails become thickened.

□ There is pain resulting from thickening and dystrophy of the infected toenails.

□ The above two statements do not apply to me. I understand I must pay for today's visit and Medicare will not reimburse me if I elect to have my toenails cut today.

______________________________ ___________________
Signature of Patient Date

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