



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: _____



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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