Burlington County Foot & Ankle, Assoc. Inc.

520 Stoke Road, Suite C5,
Medford, NJ 08055

Patient Registration Form

PATIENT INFORMATION:

Name: First M.I. Last male/female

Address: Street

City: State: Zip

Phone:(circle preference) Home Cell Work

Birth date: Age: Social Security #

Status: Married Single Widowed Partner Other

Email address:

Occupation and place of employment:

Ethnicity: Hispanic/Latino Non Hispanic/Latino prefer not to answer

Race: American Indian Asian Black/African American Pacific Islander
White/Caucasian Other prefer not to answer

Primary Language: English Spanish German Other

Emergency Contact: Name Phone #

If under 18:

Guardian-Name:

Address:

Phone:

INSURANCE:
Name of Insured (if other than self): Insured Birth date:

Primary Insurance Carrier:

Policy #: Group #:

Patient is: subscriber spouse dependent

Secondary Insurance Carrier:

Policy #: Group #:

PRIMARY PHYSICIAN:
Who is your Primary Care Physician?:

Primary Care's address and phone #:

What brought you to our office today:

REFERRAL:
How were you referred to our office?:

We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. And payment will be due at time of service.

Release of Benefits Information:
I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment is due at time of service)
ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

Patient/Guardian signature:_____date:_____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

To help us ensure your privacy please answer the following questions:

Would you allow us to leave a message on your answering machine in reference to any and all test results?_____Yes _____No

Would you like to receive your results via e-mail from the doctor?
_____Yes _____No If yes, please provide your e-mail address

_____

E-Mail Address (please print)

Do we have your permission to speak with or leave a message with anyone else (such as a spouse)?_____Yes _____No if yes, please give name and relationship of person you would like us to speak with if you are unavailable:

_____ _____

Name (Please Print) Relationship to Patient

_____ _____

Patient or Parent Signature Date

Patient Medical History - Confidential Information

Patient Name:_____

Today's Date:____/____/____ Patient's Date of Birth: ____/____/____

Lower Extremity Medical History

What is the chief reason for your visit?
(include foot,ankle,leg, and hip complaints)

_____
_____
_____
_____
_____

Any previous foot/ ankle/ leg injuries or problems?

_____
_____
_____

Haveyou been previously treated by a podiatrist?
_____ Yes _____No
Name of podiatric physician:_____
Date last seen:_____/_____/_____

General

Height:_____ Weight:_____ Shoe Size:____

Social History

Do you Smoke? _____Yes _____No
How Much? _____packs / _____
Years Smoked: _____
Drink Alcohol? _____Yes _____No
How Much: _____
Recreational Drugs? _____Yes _____No
What Type: _____
Pregnant or possibly pregnant? ___ Yes ___No
Athletic Activities in which you participate:
_____

Diabetics Only

___NIDDM ___Insulin Dependent (check one)

Insulin dosage:_____
Years Diagnosed with Diabetes:_____
Physcian treating Diabetes? _____
Date of most recent visit? _____/_____/_____

Runners Only

How long have you been running? _____
Previous running injuries? _____Yes _____No
Mileage:_____ miles per ___week ____month
Current running shoes:_____
Currently training? _____Yes _____No

Medications

List all Medications you are taking:
(including any over the counter medication or herbal remedies):

_____
_____
_____
_____
_____
_____
_____

Surgeries, Illnesses, Injuries

List surgeries, serious injuries and illnesses not previously listed:_____

_____
_____
_____
_____

Family History

List any significant family medical history.

_____
_____
_____
_____
_____

Allergies and Drug Intolerance

___ None / Unknown
___Penicillin
___Sulfa
___Local Aneathetics
___Adhesive / Tape
___Aspirin
___Codeine
___Demerol
___Iodine/Shellfish
___ Other_____

Mental / Emotional

___Yes ___No Eating Disorder
___Yes ___No Anxiety
___Yes ___No Depression
___Yes ___No Psychiatric
___Yes ___No Alcoholism

Medical History

___Yes ___No Anemia
___Yes ___No Arthritis
___Yes ___No Artifical Heart Valve
___Yes ___No Asthma
___Yes ___No Back Problems
___Yes ___No Bleeding disorder
___Yes ___No On Coumadin
___Yes ___No Cancer
___Yes ___No Chemical Dependency
___Yes ___No Chest Pain
___Yes ___No Circulatory Problems
___Yes ___No Diabetes
___Yes ___No Epilepsy
___Yes ___No Fibromyalgia
___Yes ___No Gout
___Yes ___No Heart Disease
___Yes ___No Hemophilia
___Yes ___No Hepatitis
___Yes ___No High Blood Pressure
___Yes ___No HIV Positive
___Yes ___No Kidney Problems
___Yes ___No Leg Cramps
___Yes ___No Liver Disease
___Yes ___No Lung / Respiratory
___Yes ___No Mental Illness
___Yes ___No Phlebitis/Clots
___Yes ___No Psoraisis
___Yes ___No Rheumatic Fever
___Yes ___No Stroke
___Yes ___No Thyroid Problem
___Yes ___No Tuberculosis
___Yes ___No Ulcers - Stomach
___Yes ___No Venereal Disease
___Yes ___No Weight Change
Other:_____

Patient name (print)

PATIENT ELIGIBILITY WAIVER &FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy and medical services.

It must be understood that:

-We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
-Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the services.
-Not all insurance companies/third party payors pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
-All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received
-Patients are personally responsible for knowing and understanding their own insurance policy, eligibility and coverage.
-Patients are responsible for payment of outstanding deductibles and co-insurance amounts at the time of service. Co-payments will be collected at the time of service.
-Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
-Any appointment missed or not cancelled less than 24 hours in advance might incur a fee.
-Returned checks are subject to a fee.
-Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

The patients or patient's legal representative hereby acknowledges that he/she is eligible for health insurance benefits and coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorize procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the physician accordingly.

signature date