Foot and Ankle Care
of South Jersey
Dr. Jeffrey S. Rosenman

Treatment & Rehabilitation of the Foot and Ankle

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Patient Information

Patient Name _____ Date _____

First Name Last Name Middle Initial

Birth Date _____ Age _____ Male Female

Month Day Year

Please Circle

Social Security Number _____-_____-_____

Address _____ Home Phone No. (____) _____

_____ Cell Phone No. (____) _____

City State Zip

Best Number to Reach You? Home Cell

Email Address _____

Consent to Text you at the mobile number provided? YES NO

Single Married Divorced Other

How were you referred to our office?

Google / Yahoo / Bing / Insurance Website / Online Phone Book / ZocDoc / Web Browsing / Other / Physician

_____

Spouse/Parent/Guardian Information

Name & Phone No. _____

Emergency Contact Information

Name & Phone No. _____ Relationship _____

Employer Information

Employer Name _____

Phone Number _____ Occupation _____

Insurance Information

Please Present All Insurance Cards

Primary Insurance

Name of Insurance _____

Identification Number _____ Group Number _____

Relation to Patient _____

Policy Holders Name _____ Policy Holders Date of Birth ___/___/___
MM DD YYYY

Referral Required? YES NO

Secondary Insurance

Name of Insurance _____

Identification Number _____ Group Number _____

Relation to Patient _____

Policy Holders Name _____ Policy Holders Date of Birth ___/___/___
MM DD YYYY

Who is Your Primary Care Physician? _____

Primary Care Providers Phone Number (_____)_____

Release: *I hereby authorize the release of any information acquired in the course of my examination which said insurance company may request.*

Responsibility & Assignment: *I also assign and request payment of medical benefits to the above stated physician for medical services. I also understand that I am financially responsible for payment of my bill. As a courtesy, we will bill your insurance company.*

X _____

Height: _____ Weight: _____ Most Recent Blood Pressure: _____

Shoe Size: _____ Type/style of most frequently worn shoe gear: _____

Patient Medical History

Please describe in detail the reason for your visit: _____

_____

How would you describe your pain? (Circle one) Aching Throbbing Sharp Pins & Needles Electrical Numbness

When did your problem begin? _____

What activities aggravate your condition? _____

Any prior/past treatments? (self or other): _____

Please list your past surgical history: _____

_____

Diabetic Patients: Most recent blood sugar reading (fasting/a.m.): _____ HbA1C (if known) _____

Pharmacy name address and phone number: _____

_____

Please list your current medications:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies: _____

_____

Please list any medical problems you have: _____

_____

Smoking Status (please circle) ? Never smoked Former smoker Current/daily smoker Current/some days smokes

How many years of tobacco use? _____ If you quit smoking, how long ago did you quit? _____

Deaf/Seriously impaired hearing? YES NO Blind/Vision deficit? YES NO

Difficulty concentrating/remembering? YES NO Difficulty walking/Climbing stairs YES NO

Difficulty dressing/bathing? YES NO Difficulty doing errands alone? YES NO

Alcoholic beverages? NONE OCCASIONAL MODERATELY DAILY QUIT? When? _____

Any non-prescribed or illicit Drugs (current or prior history)? YES NO _____

Have you ever had a serious illness? YES NO _____

Have you ever been hospitalized? YES NO _____

Please list <u>your family's</u> medical history (i.e. diabetes, stroke, heart disease, high blood pressure, migraines, etc:

_____

_____

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ACKNOWLEDGEMENT 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 and/or had the opportunity to read and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent/Authorized representative (if applicable)

_____

Signature

I authorize Foot and Ankle Care of South Jersey to obtain any protected health information from health care professionals who are involved in my care. I understand that this information is strictly confidential and solely used for the purpose of my medical care.

_____

Initials

Office Policy Regarding Insurance Assignment

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY!!!

Co-Payments

All copayments will be collected at the time of check-in. Your insurance company requires that you pay your co-pay at the time of your visit. If you are unable to pay your co-pay at the time of your visit, we will be happy to reschedule your appointment.

Referrals/Co-Insurance

I understand that I am solely responsible for acquiring referrals from my primary doctor PRIOR to my appointment and knowing how many visits I have been issued. If a referral was not issued, I will pay all fees for that date of service. If I do not have my referral, my visit is considered NOT COVERED by my insurance, my claim will be denied, and I will be responsible for the cost of the visit. Foot and Ankle Care of South Jersey is NOT obligated to call you primary care physician to obtain a referral for you.

For all our **Medicare** patients: We are a participating practice with Medicare, which means, we will accept the amount that Medicare approved for our services. Medicare pays 80% of their established rate for services. You as the patient are responsible for the remaining 20% of the fees either through secondary insurance or self-payments. Medicare also has a standard deductible each year that must be met before payment of services is rendered.

Acceptable methods of payment are cash, personal check, or credit/debit cards.

Foot and Ankle Care of South Jersey is required to process your insurance claims with your primary carrier. We will bill any secondary insurance as a professional courtesy to you, the patient. Please let us help you receive the maximum benefit from your insurance companies. Have a current copy of your insurance card/s handy so that we may copy them for your record. If you change health insurance during your treatment, please provide us with the updated information promptly. If you have any questions about our insurance policy, feel free to ask them at the time of your visit, or call us during normal business hours.

It is our policy to bill your insurance companies for reimbursement, however, we shall allow no more than sixty (60) days for payment. After sixty (60) days, you will be billed for any outstanding balances on your account.

The physician's office will NOT enter into a dispute with my insurance company over my claim. It is my responsibility to contact my insurance company and review my claim.

The following statement applies to me:

_____Yes, I have been associated with a malpractice suit.

_____No, I have never been associated with a malpractice suit.

By signing my name below, I indicate that I have fully read and understand the Office Policy Regarding Insurance Assignment.

_____ _____

Name (please print) Signature Date

Authorization for Release of Medical Records

I hereby authorize my primary physician to disclose (if necessary) to Foot and Ankle Care of South Jersey any information which they have obtained by examination. By signing this I release them of any consequence.

Primary Physician: _____

Signature: _____

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I was provided a written copy of the Notice of Privacy Practices. I was given the opportunity to read and understand the notice fully.

_____ _____

Patient's Name (Please Print) Date

_____

Parent or Authorized Representative

_____

Signature