# Associates In Podiatry
## Patient Registration

**First Name:** _____ **Last Name:** _____ **Male** _____ **Female** _____

**Date of birth:** _____ **SS#:** _____ **Marital Status:** M __ S __ W __ D __

**Street Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

**Occupation:** _____ **Employer:** _____

**Email Address:** _____ **Can we send emails or text messages?** _____

**Messages may be left with: Patient Only** ____ **Patient and/or Spouse** ____ **Anyone answering the phone** ____

**Emergency Contact Name:** _____ **Phone Number:** _____

**Primary Care Physician:** _____ **Phone Number:** _____

**Primary Care Physician Address:** _____ **Date Last Seen by PCP:** _____

**Preferred Pharmacy:** _____ **Phone Number:** _____

| **Government Required Information:** | | | | |
|---|---|---|---|---|
| **Primary Language:** | **English** _____ **Spanish** _____ **Other** _____ | | | |
| **Race: (circle one)** | American Indian/Alaska Native | Native Hawaiian/Pacific Islander | **Ethnicity: (circle one)** | Not hispanic or latino |
| | Asian | White | | Hispanic or Latino |
| **Decline:** _____ | Black/African American | Other | **Decline:** _____ | Unknown |

| **Primary Insurance** | | | | | |
|---|---|---|---|---|---|
| **Name** | | | **Group Name** | | |
| **ID#** | | | **Group #** | | |
| **Insured** | | **Relationship to Patient** | | **Date of Birth** | |

| **Secondary Insurance** | | | | | |
|---|---|---|---|---|---|
| **Name** | | | **Group Name** | | |
| **ID#** | | | **Group #** | | |
| **Insured** | | **Relationship to Patient** | | **Date of Birth** | |

| **Associates in Podiatry is authorized to release medical information regarding my health to the following people:** | |
|---|---|
| | |
| | |

**Name:** _____ **Birthdate:** _____ **Today's Date:**_____

**What is the chief complaint for which you came to be treated?** _____

| | | |
|---|---|---|
| **Pt. Height:** | **Pt. Weight:** | **Flu Shot: Yes ___ No ___; If yes, When?** _____ |
| **Advanced Directive?** | **Yes___ No ___** | **Pneumonia shot: Yes ____ No ___; If yes, When?** _____ |
| **List ALL Allergies:** | | |
| **List ALL Medications:** | | |
| **List ALL Surgeries:** | | |
| **List all Hospitalizations:** | | |
| **Do You Smoke?:** | **Yes _____ No _____ If yes, How much?** _____ | |

**Medical History**

**Please indicate whether you or a family member has had any of the following: (Indicate F for Father and M for Mother)**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Aids/HIV** | **You** | | **FM** | | **Eye Problems/Glaucoma** | **You** | | **FM** | | **Psoriasis** | **You** | | **FM** | |
| **Anemia** | **You** | | **FM** | | **Gout** | **You** | | **FM** | | **Psychiatric Care** | **You** | | **FM** | |
| **Arthritis** | **You** | | **FM** | | **Headaches** | **You** | | **FM** | | **Resp/COPD** | **You** | | **FM** | |
| **Artificial Heart Valves/Joints** | **You** | | **FM** | | **Heartburn/Acid Reflux** | **You** | | **FM** | | **Swelling in Ankles/Feet** | **You** | | **FM** | |
| **Asthma** | **You** | | **FM** | | **Heart Disease** | **You** | | **FM** | | **Stroke** | **You** | | **FM** | |
| **Back Problems** | **You** | | **FM** | | **Hepatitis/Jaundice** | **You** | | **FM** | | **Thyroid Dysf.** | **You** | | **FM** | |
| **Cancer** | **You** | | **FM** | | **High Blood Pressure** | **You** | | **FM** | | **Tuberculosis** | **You** | | **FM** | |
| **Chemical Dependency** | **You** | | **FM** | | **High Cholesterol** | **You** | | **FM** | | **Ulcers** | **You** | | **FM** | |
| **Circulatory Problems** | **You** | | **FM** | | **Kidney Problems** | **You** | | **FM** | | **Varicose Veins** | **You** | | **FM** | |
| **Colitis/Chrohn's** | **You** | | **FM** | | **Liver Disease** | **You** | | **FM** | | **Venereal Disease** | **You** | | **FM** | |
| **Diabetes** | **You** | | **FM** | | **Neuropathy** | **You** | | **FM** | | **Other** | **You** | | **FM** | |
| **Epilepsy/Sizures** | **You** | | **FM** | | **Pacemaker/Defib.** | **You** | | **FM** | | | **You** | | **FM** | |

I have read a copy of Associates in Podiatry's NOTICE OF PRIVACY PRACTICES in accordance with the new HIPAA regulations.

Physician's release and agreement: I hereby authorize payment directly to Associates in Podiatry of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers and information needed for this or a related Medicare claim. I request payment of medical insurance benefits wither to myself or to the party who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. If I fail to pay any outstanding balances, I will also incur any charges associated with the collection of these fees.

I understand I will be responsible for any fees incurred because I did not provide accurate insurance information at the time of service. This includes not getting authorizations when required.

**Patient Signature:** _____ **Date:** _____

**Patient Name (Print):** _____

# REVIEW OF CURRENT SYMPTOMS

Please review the following carefully and *circle any of the symptoms* that you may be experiencing:

CARDIOVASCULAR: ankle swelling, calf cramping, change in temperature of extremity, cold feet, murmur, pacemaker, shortness of breath, tightness in chest, varicosities;

CONSTITUTIONAL: anxiety, appetite decrease, appetite increase, chills, dizziness, headaches, hot flashes, migraines, night sweats, sleep problems, thirst, tiredness, vertigo, weight gain, weight loss-intentional, weight loss-unintentional;

ENDOCRINE: cold intolerance, cuts take longer to heal, dry hair, dry skin, excess hair growth, heat intolerance, hyperglycemia, hypoglycemia, recent hair loss;

EARS,NOSE,MOUTH,THROAT: bleeding gums, bloody nasal discharge, cough, difficulty with hearing, dry throat and/or mouth, loss of sense of smell, painful teeth, post-nasal drip, ringing in ears, runny nose, tinnitus;

EYES: blurred vision, dry eyes, excess tearing/watering, itchy eyes, pin or soreness in or about the eyes, photo sensitivity, reddened eye(s);

GASTROINTESTINAL: abdominal pain, abdominal distension, blood in stool, bowel habit change, constipation, diarrhea, excess gas, heartburn, nausea, vomiting;

GENITOURINARY: blood in urine, burning with urination, discharge, flank pain, herpes outbreak, impotence, polyuria, urinary frequency, urinary incontinence, urinary urgency;

IMMUNOLOGIC: arthritic flare-up, asthma attack recently, coughing, environmental allergies, eyes watering, hay fever symptoms, seasonal allergies;

INTEGUMENTARY: athlete's foot, blisters, burning of skin, dry/scaly skin, eczema, hair loss, hypersensitivity of skin, hypertrophic scars, lower leg ulcers, non-healing wounds, psoriatic flare-up, rash, sunburn, tingling sensation;

LYMPHATIC: anemia, ankle edema, bleeding tendency, bruise easily, calf pain, fatigue, frequent nose bleeds, increased time to stop bleeding, leg swelling, recent night sweats, swollen lymph nodes, water retention;

MUSCULAR/SKELETAL: abdominal pain, back pain, heel pain, hip pain, joint redness, joint swelling, leg cramps, morning stiffness, muscle tenderness, stiffness, weakness;

NEUROLOGICAL: burning, facial tick, hypersensitivity, numbness, paralysis, recent seizure, stocking and glove numbness, tingling, tremors;

PSYCHIATRIC: addiction to alcohol, anger, anxiousness, attempted suicide, claustrophobic, depression, disorientation, emotional or mental abuse, irritability, memory loss, nightmares, overreacting, panic attacks, paranoia, poor anger control;

RESPIRATORY: breathing difficulty, chest pain with inspiration, cold-like symptoms, coughing up excess sputum, flu-like symptoms, recent asthma attack, sleep apnea, snoring, wheezing

_____ _____

Initials Date

# Associates in Podiatry

*"First Step To Healthy Feet"*

Podiatric Medicine and Surgery

Dr. Todd E. Stevens
Dr. Noah Stark

## Office Policy Regarding "Payment of Services"

In order to maintain optimal relationships between staff and patients and to avoid misunderstandings regarding our payment policies, we ask that you read and sign the following:

- It is the patients responsibility to provide updated and accurate demographic and insurance information at each visit. Failure to do so may result in the bill becoming the patients responsibility regardless of insurance coverage.
- There is a $30.00 charge for all returned checks.
- There is a $50.00 charge for missed or canceled appointments with less than 24 hour notice. This charge is not reimbursable by the patients insurance.
- Our office will try to confirm appointments as a courtesy service. It is not an obligation. If you fail to keep your appointment and we were unable to confirm, you may still be responsible for the $50.00 charge.
- Payment is due in full at the time of appointment if you do not have insurance coverage or if we do not participate with your plan.
- Please understand that your insurance card is not a guarantee of payment, the patient is ultimately responsible to the practice for payment on all services regardless of insurance coverage.
- It is the patients responsibility to know the provisions of their insurance plans.
- If you have more than one insurance policy, you must provide us with all your ID cards at the time of check in. Your primary insurance usually covers a portion of basic and major procedures. Your secondary and any other insurances that you may have may pick up some or all of the remaining balance. If you have a secondary and fail to give us the information, YOU will be responsible for payment of the balance.
- All co-pays are due at the time of service. If we participate with your insurance plan, we will submit your claim provided that you will be responsible for any amount that becomes patient liability. (Including, but not limited to all co-pays, deductibles, co-insurance and non covered services under your plan.
- All co-pays, deductibles, co-insurance and non covered services will be collected at the time of service based on your insurance policy's fee schedule.
- If you need a referral, it is YOUR responsibility to obtain the referral before your visit. (Check with your insurance company to be sure if a referral is needed.) We try our best to remind you if you need a new referral; however, it is ultimately your responsibility to keep track of your referrals.
- Please be advised that common podiatric services such as routine foot care, ie; cutting of toenails and paring or debridement of corns and callouses, may not be a reimbursable service by your insurance company. Associates in Podiatry will make every attempt to bill and collect payment from your insurance company. In the event that your insurance company does not provide reimbursement, you may be billed and held responsible.

We thank you for your cooperation in this matter.

Your signature below indicates that you have read, understood and agree to abide by the above policy.

_____ _____

Patient Signature Date

318 Chestnut Street
Roselle Park, NJ 07204
908.687.5757
FAX: 908.241.1172

4491 Route 27
Princeton, NJ 08540
609.924.8333
FAX: 609.924.8663