PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate _____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____

Birthdate _____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for any services furnished me by that physician. 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

3 PHONE NUMBERS

Home_____ Work_____ Ext_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list.

Name_____

Last visit_____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation_____

Cigarette/Tobacco use _____

Years smoked_____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Callouses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar's Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

– OVER –

5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
			Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
			Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

7 ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankle and / or lower leg.

Patient's Signature _____ Date _____

MY MEDICATION LIST

Patient Name: _____ Date: _____

Date of Birth: _____

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. ***Bring this list with you to your first appointment.***

Drug Name	Drug Strength	Amount and Times of Day Taken	Reason for Medication	Prescriber

Do you have any allergies? _____ Yes _____No

If yes, please list:

_____

_____

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JERSEY SHORE FOOT & LEG CENTER
Michael Kachmar, DPM
Vincent Delle Grotti, DPM
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Bayville, NJ 08721
(732) 269 - 1133

Notice Of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date Of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this Practice, my individual rights, how I may exercise these rights, and the Practice's legal duties with respect to my information.

I understand that this Practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this Practice. I understand I can obtain this Practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient)

_____

Jersey Shore Foot & Leg Center
Dr. Michael G. Kachmar
Dr. Vincent DelleGrotti

DATE: _____

OFFICE BILLING PROTOCOL & APPOINTMENT CANCELLATION:

Appointments must be canceled 24 hours in advance or an office visit will be charged directly to the patient; in the amount of $65.00. If the patient's appointment is a surgical procedure, the amount of $100.00 will be charged to the patient.

Any patient responsibility after insurance will be billed directly to the patient for payment. All balances not paid within 30 days will incur a finance charge unless you require a payment plan. If a payment plan is required you must contact the billing department to make payment arrangements.

Once again any balance that is patient responsibility and billed to the patient must be paid within 30 days to avoid interest.

If your account should be turned over for collections your account will also incur interest.

PRINT NAME: _____ DOB: _____

SIGNATURE: _____

ADDRESS: _____

_____

Jersey Shore Foot & Leg Center
Dr. Michael G. Kachmar
Dr. Vincent DelleGrotti

DATE: _____

For oral communications, (Confirm Appointments, Billing Information, Results, Ect.) We may leave a message at the following numbers with the following people...

NAME _____ RELATIONSHIP _____ PHONE# _____

PHONE NUMBERS WE MAY CONTACT YOU AT:

HOME: _____

WORK: _____

CELL: _____

EMAIL ADDRESS:_____

MAY WE EMAIL YOU CONCERNING NEW PRODUCTS, PROMOTIONAL ITEMS AND/OR NEW PODCAST EPISODES: YES_____ NO :_____

PRINT NAME: _____ DOB: _____

SIGNATURE: _____

ADDRESS: _____

_____