FOOT AND ANKLE CENTER, LLC

IRINA TSYGANOVA, D.P.M DEBORAH ROSENFELD, D.P.M.

3003 English Creek Avenue, Suite C-5
Egg Harbor Township, NJ 08234
(609)272-1450 Fax (609)272-1445

PATIENT NAME:_____ **DATE:**_____

Birth Date:__/__/__ **Age**:__ **Gender**: Male__ Female __**Social Security** #:_____

Mailing Address: _____**City**:_____ **State**:____ **Zip**:_____

Best Phone Number: _____ **Secondary #**:_____ **Email**:_____

May we call and leave a message on your answering machine? Yes__ No__

Status: Minor__ Single__ Married__ Divorced__ Separated__ Widow__

Employer:_____ **Occupation**:_____

Address:_____ **Work Phone**:_____

Primary Language:_____ **Ethnicity**: Hispanic or Latino Not Hispanic or Latino

Race: White____ African American____ Asian____ Other_____

How did you hear about us?_____

Insurance Name: _____

ID#:_____ **Group#**:_____**Plan#**:_____

Insured's Name: _____**Social Security#**_____**Birth date**: __/__/____

Secondary Insurance:_____

ID#_____ **Group#**_____ **Plan#**:_____

Emergency Contact: _____ **Relation**:_____ **Phone#**:_____

Primary Care Doctor: _____ **Phone#**:_____

Location/Address:_____ **Last Physical Exam:** __/__/__

Pharmacy:_____**Address**:_____ **Phone#**:_____

Reason for visit: _____

Please describe pain and its location: _____

When did condition begin? _____ Is it getting worse? _____

Is this an Injury: YES/NO If yes, when did it occur? ___/___/___

MEDICATIONS

Medication	Dosage	How Often Taken?	What is it Taken for?

DRUG ALLERGIES

__Penicillin __ Codeine __Sulfa __Iodine __Aspirin __Cortisone __Latex __Anesthetics
Other: _____

MEDICAL HISTORY

__ Diabetes __ Fibromyalgia __Tumors __Nerve Condition __Heart Problems __Gout __Arthritis
__Asthma __COPD __Skin Disorders __Tuberculosis __Anemia __Bursitis __AIDS (HIV) __Stroke

__Lung Disease __Kidney Problems __Sickle Cell __Hepatitis __Osteoporosis __Bleeding Problems
__Mental Disorders __Poor Circulation __Heart Burn/Reflux __High Blood Pressure __Joint Implants
__Thyroid Disease __Rheumatic Fever __High Cholesterol Cancer Type: _____

Other: _____

_____ **Diabetes; what is the name, phone number, and address of the doctor treating you for diabetes?**

_____

When was your last visit? ___/___/____ What is your average blood sugar reading? _____

Are you pregnant? ___Yes ____No What is your Hemoglobin A1C? _____

How many months? _____

SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATIONS

Have you ever had any injury to the lower extremity? ___ Yes ___ No Explain _____

Height: _____ Weight: _____ Shoe Size_____

SOCIAL HISTORY

Do you drink alcohol? Yes/No How much? __1-2 per week __1-2 per day

Do you smoke? Yes/No If Yes: ___ # cigarettes per day? ___ # of years Smoking?

Did you ever smoke? Yes/No If Yes: When did you stop? ____

FAMILY HISTORY ***Please check all that apply**

	FATHER	**MOTHER**
Diabetes		
Heart Disease		
High Blood Pressure		
Arthritis		
Gout		
Thyroid		
Cancer (what type)		
Other		

REVIEW OF SYSTEMS ***If you are experiencing any of the following please **CIRCLE**:

Constitutional: Chills, Fever, Headache, Night Sweats.

Eyes: Blurred vision, Loss of vision, Glaucoma, Macular Degeneration.

ENMT: Cough chronic, Difficulty swallowing, Sinus congestion.

Integumentary: Athletes foot, Dry scaly skin, Hair loss, Itchy skin, Toe nail fungus.

Allergic: Environmental allergies, Drug allergies.

MSK: Back pain, Foot pain, Heel pain, Joint pain, Leg cramps.

Neurological: Burning, Neuropathy, Numbness, Tingling.

GU: Kidney dialysis, Painful urination, Urinary frequency.

Endocrine: Cuts take longer to heal, Dry skin, Extreme thirst, Hyperglycemia.

Respiratory: Asthma, Breathing difficulties, COPD, Emphysema.

GI: Abdomen pain, Constipation, Diarrhea, Heartburn.

CVS: Chest pain, Shortness of breath, Pace maker, Edema.

Hematologic: Blood clots, History of blood thinners.

Psychiatric: Depression, Psychiatric or Emotional difficulties.

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.**
- **Obtain payment for third-party payers.**
- **Conduct normal healthcare operation such as quality assessments and physician certifications**

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change it s Notice of Privacy Practices from time to time; and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand that you are not required to agree to my requested restrictions. However, if you agree; you are bound to abide by such restrictions.

I give my permission for this office to leave a message on my answering machine and/or with a family member.

I understand that I may revoke this consent in writing at any time; except to the extent that you have taken action relying on this consent.

FINANCIAL POLICY

We accept assignment of insurance benefits. However, we require that all co-pays and non-covered services be paid at time of service. We will bill your insurance company. Your insurance policy is a contract between you and your insurance company. We are not part of the contract. If your insurance company does not pay your account in full the balance will be your responsibility. If a claim is denied by your insurance company and needs to be appealed you delegate that to Foot and Ankle Center and/or our billing agent to do on your behalf. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and other medical insurances.

I understand and agree to this policy.

Print Patient Name: _____

Signature of Patient/Guardian: _____

Relationship to Patient: _____Date: _____