Associates In Podiatry
Patient Registration

Patient Name				**Gender**	**Male _____ Female _____**
Birthdate		**Age**		**SS#**	
CURRENT ADDRESS					
Address		**City, State, Zip**			

COMMUNICATION					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**SMS or Text?**	**Yes _____ No _____**		
Who may we leave a message with?	**Patient Only _____ Patient and/or Spouse _____ Anyone answering the phone _____**				
Email					

GOVERNMENT REQUIRED INFORMATION **Check One in EACH Section**			
Primary Language	□ English □ Spanish □ Other □ Other: _____		
Race	□ American Indian or Alaska Native □ Asian □ Black or African Amercian □ Native Hawaiian or other Pacific Islander □ White □ Other Race □ Decline to Answer	**Ethnicity**	□ Not hispanic or latino □ Hispanic or Latino □ Unknown □ Decline to Answer

Do you Smoke ?	Yes _____ No _____	**If yes, How Much?**	
Do you Drink Alcohol?	Yes _____ No _____	**If yes, How Much?**	
Do you use Recreational drugs?	Yes _____ No _____	**If yes, How Much?**	

INFORMATION			
Marital Status	M ___ S ___ W ___ D ___	**Employer**	
Occupation		**Employer Phone/Address**	

Pt. Height:	**Pt. Weight:**	**Flu Shot: Yes_____ No _____; If Yes, when?_____**
List all Allergies:		
List all Medications:		
List all Surgeries:		
List all hospitalizations:		

Who may we thank for referring you? _____

PRIMARY INSURANCE					
Name		**Group Name**			
ID #		**Group #**			
Address					
Phone					
Insured		**Relationship to patient**		**Date of Birth**	

SECONDARY INSURANCE					
Name		**Group Name**			
ID #		**Group #**			
Address					
Phone					
Insured		**Relationship to patient**		**Date of Birth**	

EMERGENCY CONTACT		
Name	**Relationship**	**Phone #**

Primary Care Physician		**Date last seen:**	
PCP Address		**PCP Phone:**	
Preferred Pharmacy		**Pharm. Phone:**	
Pharmacy Address			

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

I have read a copy of the Associates In Podiatry 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 any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the part 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. This includes not getting authorizations when required.

Patient's Signature:_____ **Date:** _____

Patient Name (Print:)_____

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

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

Medical History

Please indicate whether you or a family member has had any of the following:

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 ____	Respiratory Disease/COPD	You____ FM ____
Artificial Heart Valves/Joints	You ____FM ____	Heartburn/Acid Reflux	You ____FM ____	Stroke	You____ FM ____
Asthma	You ____FM____	Heart Disease	You ____FM ____	Swelling in Ankles/feet	You ____FM ____
Back Problems	You____ FM ____	Hepatitis/Jaundice	You ____FM ____	Thyroid Dysfunction	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 Disease	You ____FM ____	Liver Disease	You ____FM ____	Venereal Disease	You ____FM ____
Diabetes	You ____FM ____	Neuropathy	You ____FM ____	Other _____	
Epilepsy/Seizures	You____ FM____	Pacemaker/Defib.	You ____FM ____	_____	

Review of Current Systems

Please review the following carefully and **CIRCLE** any symptom that you may be experiencing:

Constitutional: appetite decrease, appetite increase, chills, dizziness, headaches, hot flashes, migraine, night sweats, sleep problems, thirst, vertigo, weight gain, weight loss;

Cardiovascular: ankle swelling, calf-cramping, change in temp of extremity, cold feet; murmur, pacemaker, varicosities

Endocrine: cold intolerance, cuts take longer to heal, dry hair, dry skin, heat intolerance, hyperglycemia, hypoglycemia;

Ear, Nose, Mouth, Throat: bleeding gums, bloody nasal discharge, cough, difficulty with hearing, dry throat and/or mouth, lost sense of smell, painful teeth, post-nasal drip, ringing in ears, runny nose, tinnitus;

Eyes: blurred vision, discharge, dry eyes, excess tearing/watering, itchy eyes, pain or soreness in or about the eyes, photosensitivity, reddened eye(s);

Gastrointestinal: abdominal pain, abdominal distension, blood in stool, constipation, diarrhea, excess gas, heartburn, nausea;

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: blisters, burning of skin, dry/scaly skin, eczema, hair loss, hypersensitivity of skin, hypertrophic scars, non-healing wounds, psoriatic flare-up, rash, sunburn, tingling sensation;

Lymphatic: anemia, bleeding tendency, bruise easily, fatigue, frequent nose bleeds, increased time to stop bleeding, recent night sweats, swollen lymph nodes, water retention;

Muscular/Skeletal: abdominal pain, back pain, hip pain, joint redness, joint swelling, leg cramps, morning stiffness, muscle tenderness, stiffness, weakness;

Neurological: burning, facial tick, hypersensitivity, numbness, paralysis, recent seizure, 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, flu-like symptoms, recent asthma attack, sleep apnea, snoring, wheezing

Associates in Podiatry

"First Step To Healthy Feet"

Podiatric Medicine and Surgery

Dr. Todd E. Stevens
Dr. Danny J. Gomez

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 hours 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 of 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; the 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 you 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

Associates in Podiatry

"First Step To Healthy Feet"

PODIATRIC MEDICINE AND SURGERY

DR. TODD E. STEVENS
DR. DANNY J. GOMEZ

DATE:_____

PATIENT:_____

I understand that it is my responsibility to have a valid referral, if needed, for each visit to ASSOCIATES IN PODIATRY.

For today _____,

_____ I have my referral;

_____ I do not require referrals;

_____I do not have a valid referral because:

_____I did not obtain a referral from my Primary Care Physician. I am knowingly self-referring and understand I will be responsible for any charges.

_____I did not obtain referral from my Primary Care Physician because I did not believe it was required. I understand that if I am incorrect I will be responsible for any charges.

_____My Primary Care Physician did refer me, but your office has not received the appropriate referral. I understand it is my responsibility to contact my Primary Care Physician and obtain the necessary authorization for this visit. If I am unable to obtain this referral, I understand I will be responsible for any charges.

_____I did not obtain prior authorization from my Primary Care Physician and choose to reschedule my appointment and bring a referral with me.

_____ _____

Signature Date

318 Chestnut Street
Roselle Park, NJ 07204
Phone: 908-687-5757
Fax: 908-241-1172

4491 Route 27
Princeton, NJ 08540
Phone: 609-924-8333
Fax: 609-924-8663