WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

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 Calluses	☐ 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 Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

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

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

_____

_____

MEDICATIONS

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

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

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

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____

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ADVANCED FEET & ANKLE CARE
DR. JASON M. GROSSMAN, D.P.M.
2477 HIGHWAY 516
SUITE 201
OLD BRIDGE, NJ 08857
TELEPHONE # 732-679-4330
FAX# 732-679-4777

PLEASE FILL OUT THE FOLLOWING INFORMATION TO THE BEST OF YOUR KNOWLEDGE:

HEIGHT: _____

WEIGHT: _____

BLOOD PRESSURE: _____

DO YOU SMOKE? _____

HAVE YOU EVER SMOKED? _____

Advanced Feet & Ankle Care
Dr. Jason M. Grossman D.P.M.
2477 Highway 516
Old Bridge, New Jersey 08857
732-679-4330

Welcome to our practice. We will need the following information, which is now requested by the insurance companies.

Your Primary Care Physician's Name:

_____

Address: _____

_____

_____

Phone #: _____

Thank you.

ADVANCED FEET AND ANKLE CARE
DR. JASON M. GROSSMAN, D.P.M.
2477 HIGHWAY 516
OLD BRIDGE, NJ 08857

PLEASE READ OFFICE POLICY AND PROCEDURES THEN SIGN. THANK YOU.

PLEASE REFRAIN FROM CELL PHONE USE INSIDE OUR OFFICE.

PLEASE NOTIFY THE FRONT DESK STAFF WITH ANY CHANGES TO YOUR ADDRESS, PHONE, INSURANCE.

PLEASE ALLOW A 72 HOUR TURN AROUND FOR ANY MEDICAL RECORD COPIES OR DISABILITY PAPERS.

REFERRALS ARE THE PATIENT'S RESPONSIBILITY TO TRACK AND PROVIDE THE STAFF UPON YOUR VISIT.

COPAYS ARE DUE UPON CHECKING IN AT THE WINDOW. YOU WILL BE CHARGED A COPAY EACH VISIT YOU ARE SEEN.

OFFICE HOURS ARE AS FOLLOWS:

MONDAY	9-5
TUESDAY	9-7 (BREAK FROM 1-3)
WEDNESDAY	9-2
THURSDAY	9-7 (BREAK FROM 1-3)
SATURDAY	9-12

THERE ARE NO OFFICE HOURS ON FRIDAYS OR SUNDAYS.

WE HAVE AN OFFICE AT 53 MAIN STREET IN SAYREVILLE AND WE ARE THERE EVERY THURSDAY MORNING FROM 9-12. ASK THE FRONT DESK FOR INFORMATION. THANK YOU.

PATIENT'S SIGNATURE: _____ DATE: _____.