Foot & Ankle Center
of New York
Skybridge Healthcare
Akamai • Wexler Foot Care

We are glad to have you as a patient. Please answer the following questions to help us become better acquainted. If you need any help, please do not hesitate to ask us for assistance.

Patient Information

Last Name_____ First Name_____ MI_____

Street_____ City/State_____ Zip_____

Phone **(_____)** _____-_____ Cell **(_____)** _____-_____ Sex **M F**

SS # _____-_____-_____ Date of Birth _____/_____/_____

Marital Status **S M W D**

Email Address _____ May we contact you via email? **Yes No**

Emergency Contact Name_____ Phone # **(_____)** _____-_____

Relationship to You_____

Whom may we thank for referring you to us?_____

CIRCLE ONE: Are You Employed? **Yes No** May we contact you at work? **Yes No**

Name of Employer _____ Phone # **(_____)** _____-_____

Address of Employer _____

Personal Medical History

Weight _____ Shoe size _____

Name, address and phone number of your primary care physician _____

_____

What is the reason for your visit today? _____

_____

Allergies to medication _____

Other Allergies _____

Last Name: _____ **First Name:** _____

Please list any medication that you are currently taking.

Medication Name	**Medication Dosage**	**How Do You Take it? (by mouth, injection, cream, etc.)**	**When/How Often Do You Take it?**
Example: Motrin	200 mg	By mouth	In the morning

X_____ _____

Signature of patient or patient's guardian Date

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Last Name: _____ **First Name:** _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Diabetes	**Y N**	Kidney Disease	**Y N**
Liver Disease	**Y N**	Heart Disease	**Y N**
Lung Disease	**Y N**	Joint Replacement	**Y N**
Stomach Problems	**Y N**	Joint Pain	**Y N**
Are You Pregnant?	**Y N**	Bleeding/Clotting	**Y N**
Problems			
Do you Smoke?	**Y N**	Do you Drink?	**Y N**

If so how much? _____ If so how much?_____

Do you or have you ever used recreational drugs? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Hepatitis?	**Y N**	If yes, what type? _____
Any type of transplant?	**Y N**	If yes, what type? _____
Any form of cancer?	**Y N**	If yes, what type? _____

If so, have you had chemotherapy or radiation treatments? _____

Personal or family history of malignant melanoma? **Y N** who? _____

Any hospital admissions? **Y N** When and why _____

_____

Have you had any surgery? **Y N** When and why? _____

_____

Please list any current illnesses or medical conditions _____

_____

Please list any family history of any medical conditions _____

_____

Any current illness or additional information that you would like the doctor to know?

_____

PODIATRIC HISTORY

Have you ever been to a podiatrist before? **Y N** When? _____

Name of Doctor _____ What type of treatment did you have?_____

_____

HEALTH INSURANCE INFORMATION

Patient Name_____

Do you have health insurance? Y N

Who is your health insurance carrier? Primary_____ Secondary_____

Policy Holder's Name_____ **DOB** _____

If the patient is under 18, who is responsible for the patient's medical bills?

Name_____ **DOB** _____

Address _____

PLEASE READ, SIGN AND DATE THE FOLLOWING INFORMATION

I hereby consent to be treated by the physicians of the Foot and Ankle Center of New Jersey either in person or through Telemedicine.

I understand that if I do not have insurance coverage, I will be responsible to pay Foot and Ankle Center of NJ on the day of service.

I understand that if my insurance carrier does not pay any amount due for services rendered that I will be responsible for full payment upon request. Such services include but are not limited to: any amount that has been applied to my deductible; any service not approved on my referral (if such form is required by my plan); any service considered to be cosmetic in nature and/or not covered by my insurance plan; any copay or coinsurance designated by my insurance plan.

I am aware that I have a deductible. _____ (please initial)

I understand that if I fail to obtain a referral from my primary care physician when such form is required by my plan, then I will be responsible for payment.

I hereby agree to pay Foot and Ankle Center of NJ for any non-covered services rendered.

I hereby authorize the release of information necessary to file a claim with my insurer, and/or which is pertinent to my case to any insurance company involved with my case, or to my primary care physician if requested. In addition, I authorize payment from Medicare or any other insurance company to be made on my behalf to the above facility.

A copy of this signature is as valid as the original.

X_____Date_____

Signature of patient or patient's guardian

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Authorization to Release Information

Patient Name_____

PLEASE READ, SIGN, AND DATE THE FOLLOWING INFORMATION

I hereby authorize the release of information necessary to file a claim, with my insurer, which is pertinent to my case to any insurance company involved, including any insurance company or attorneys handling a worker's compensation claim or personal injury claim.

In addition, I authorize the release of all medical records or any other pertinent information to other health care providers or organizations responsible for global treatment.

A copy of this signature is as valid as the original.

X_____ _____
Signature of patient or patient's guardian *Date*

X_____ _____
Signature of witness *Date*

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. I also understand that I may be subject to a $50 fee if I fail to show up to my scheduled appointment without prior notification to the office.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature