PATIENT INFORMATION

PRINCETON REGIONAL FOOT & ANKLE ASSOCIATES

Name:_____ PT. ID:_____

Address:_____

City, State, & Zip:_____

E-mail_____

Phone:_____ ☐Home ☐Work ☐Cell ☐Other

Phone:_____ ☐Home ☐Work ☐Cell ☐Other

Sex ☐ Male ☐Female

Date of Birth:_____ Age:_____

Social Security #:_____

Marital Status: ☐Married ☐Single ☐Divorced ☐ Widowed

Referring Physician:

Referring Physician Address:_____

_____

Primary Physician:_____

Referral Source:_____
(How did you hear about our Practice)

PRIMARY INSURANCE ☐Same as Patient ☐Same as Guarantor ☐Other

Insurance Company:_____

Insurance Address:_____

City, State, Zip:_____

Insurance Phone#:_____

Insurance ID#:_____

Policy Group#:_____

Insured Policy Holder:_____

Insured Phone:_____

Relationship to Policy Holder:_____

Insured Date of Birth:_____

Insured Social Security #:_____

SECONDARY INSURANCE ☐Same as Patient ☐Same as Guarantor ☐Other

Insurance Company:_____

Insurance Address:_____

City, State, Zip:_____

Insurance Phone#:_____

Insurance D#:_____

Policy Group#:_____

Insured Policy Holder:_____

Insured Phone:_____

Relationship to Policy Holder:_____

Insured Date of Birth:_____

Insured Social Security #:_____

ACCIDENT INFORMATION

Accident ☐Yes ☐No ☐Work Group ☐ Auto ☐ Other

Date of Injury:_____

Time of Injury:_____

EMERGENCY CONTACT (not living with you)

_____
(Name) (Relationship) (Phone

PATIENT EMPLOYMENT

☐Employed ☐Retired ☐Other

Employer:_____

Address:_____

City, State, Zip:_____

Phone:_____

Occupation:_____

PHARMACY INFORMATION

Pharmacy Name:_____

Address :_____

City, State, Zip:_____

Phone:_____

Patient Release

Release: I hereby consent to the release of information provided to, or generated by Princeton Regional Foot & Ankle Associates to my primary care physician, referring physician, physical therapist, attorney, insurance carrier(s), agency or other party with a bona fide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.

Assignment: I hereby assign medical benefits otherwise payable to me to Princeton Regional Foot & Ankle Associates. I understand and agree I am financially responsible for all co-pays, deductibles, co-insurance and balances.

Self-Pay: I understand that payment in full is due at the time services are rendered.

Consent to Treatment: I hereby consent to examination and treatment by Princeton Regional Foot & Ankle Associates.

Verification: I hereby verify that all the above information is true and correct as of the date signed below.

Patient's Signature_____ Date: _____

PRINCETON REGIONAL FOOT & ANKLE ASSOCIATES
PATIENT MEDICAL HISTORY

NAME:_____ AGE:_____ DATE:_____

PRIMARY LANGUAGE: ☐English ☐Spanish Other (Specify) _____

RACE: ☐ Am. Indian/ Alaskan Native ☐ Asian ☐ Black/African Am. ☐ Native Hawaiian or/Pac. Isl. ☐ White ☐Not Specified

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Specified.

OCCUPATION:_____

MEDICAL DOCTOR'S NAME:_____

WHY ARE YOU SEEING THE DOCTOR TODAY?_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____ HOW MANY TIMES?_____

HAS THERE BEEN PRIOR MEDICAL TREATMENT? ☐Yes ☐No IF "YES," BY WHOM?_____

Do you have any medical problems? Please circle all that apply.

	Other
Constitutional: Dizziness, Chills	
Eyes: Glaucoma, cataracts	
Ears/Nose/Mouth/Throat: Tinnitus, halitosis, hearing loss, difficulty swallowing	
Cardiovascular: Congestive heart failure, heart attack, palpitations, high blood pressure, stroke	
Respiratory: Asthma, shortness of breath, sleep apnea, snoring	
Gastrointestinal: Nausea, vomiting, diarrhea, blood in stool	
Genitourinary: Painful urination, blood in urine, frequent urination, impotence, STD	
Musculoskeletal: Back pain, joint pain, muscle pain, bone pain, arthritis	
Integumentary: Dermatitis, eczema, tinea pedis, psoriasis, rash	
Neurological: Anesthesia, paresthesia, seizures, tremors	
Psychiatric: Anxiety, depression, binging, paranoia	
Endocrine: Diabetes, thyroid disease, fatigue, unexplained weight loss	
Hematologic/Lymphatic: Anemia, leukemia, lymphoma, bloating, swelling, pitting edema, inability to stop bleeding	
Immunologic: Allergies, gout, rheumatic disease	
Allergies: Please list No known allergies ☐	

Previous Surgeries, Illness or Hospitalizations	Year

What Medications Do You Take? Please List Dose and Schedule (How Many Times a Day)

Height: ft. _____ in. _____ Weight: _____ Blood Pressure: _____

Do you smoke? ☐Yes ☐No Packs per day _____

Do you drink? ☐Yes ☐No ☐ Rarely ☐ Socially ☐Daily

If Diabetic: Last fasting blood sugar: _____ Last HgbA1c: _____ Shoe size: _____

Family history: Please List _____ ☐Unremarkable

Reviewed By:_____ MD Date:_____

Princeton Regional Foot & Ankle Associates

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Princeton, NJ 08540
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Fax (609) 924-8532

Reconstructive Foot & Ankle Surgery • Sports Medicine • Pediatric Foot Disorders • Total Foot Care

Patient Name: _____ **Date of Birth:** _____

I have received this practice's Notice of Privacy Practices, which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses in disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be sued against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that 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): _____