

# WAYNE FOOT AND ANKLE CENTER, P.A. - REGISTRATION

246 Hamburg Turnpike Suite 204 Wayne, NJ 07470

www.waynefoot.com

## 1 PATIENT INFORMATION

Date: \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ DOB \_\_\_\_\_

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Who referred you to our office?  
\_\_\_\_\_

## 2 PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email: \_\_\_\_\_

Which contact number is preferred?  H  W  C

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## 3 INSURANCE

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

Coverage Holder \_\_\_\_\_

Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_

Coverage Holder \_\_\_\_\_

Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_

I, the undersigned certify that I (or my dependent) have coverage with the above mentioned insurance company(ies) and assign directly to Wayne Foot and Ankle Center, PA 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Wayne Foot and Ankle Center, PA for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

Please indicate which foot problems you now have or have had in the past.

I understand that the Patient Privacy Act Notices is available upon request.

Signature: \_\_\_\_\_

If due to injury, was it at work? \_\_\_\_\_ at home? \_\_\_\_\_  
car accident? \_\_\_\_\_ When did it happen? \_\_\_\_\_

## 4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh and hip complaints.)  
\_\_\_\_\_  
\_\_\_\_\_

Is there any personal or family history of diabetes?  Yes  No

Cigarette/Tobacco use \_\_\_\_\_

Years smoked \_\_\_\_\_

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's Warts  Yes  No

Swelling in Ankles or Feet  Yes  No

Tired Feet  Yes  No

## 5 MEDICAL HISTORY

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

Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, Unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Surgeries you have had \_\_\_\_\_

Hospitalization other than for the surgeries listed \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any doctor's care for any reason over the past two years?  Yes  No

If yes, please explain \_\_\_\_\_

## 6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) \_\_\_\_\_

Do you take oral contraceptives?  Yes  No

## 7 ALLERGIES

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocain
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
Other _____	

## 8 CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of any medical conditions within the doctor's scope of practice.

Patient/Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_