Old Bridge Office
99 Old Matawan Road
Old Bridge, NJ 08857
(732) 679-4330

ADVANCED
FEET AND ANKLE CARE

Dr. Jason M. Grossman, DPM
Dr. Paul A. Osemene, DPM

Freehold Office
4249 US-9
Freehold, NJ 07728
(732) 679-4330

A Division of New Jersey Podiatric Physicians & Surgeons Group, LLC

Patient Information Form

(Please Print Clearly)

Date: _____

Patient Name: _____

Date of Birth: ____/____/_____ Age: _____ Sex: M _____ F _____

Primary Language: _____ Race: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____-_____

Email Address: _____ (will not be shared)

Employer:

Name of Employer: _____ Work Phone: (_____) _____-_____

Emergency Contact:

Name _____ Relationship: _____ Phone: (_____) _____-_____

Primary Care Doctor:

Dr. Name _____ Date Last Seen: ____/____/_____

Phone: (_____) _____ - _____ City/State: _____ Zip: _____

Pharmacy Info:

Name: _____ Location: _____ Phone: (_____) _____-_____

Payment Info:

Who is responsible for Payment: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

Phone: (____) _____-_____ Who Referred You To Us? _____

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MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER AND HERBAL SUPPLEMENTS):

Medication Name	Dose	How often do you take?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐PARTNERED ☐SEPARATED ☐DIVORCED ☐WIDOWED

USE OF ALCOHOL: ☐NEVER ☐NO LONGER USE ☐HISTORYOF ALCOHOL ABUSE

CURRENT USE – TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐NEVER ☐QUIT – How Long Ago? _____ ☐ SMOKE _____Packs/Day For _____Years

USE OF RECREATIONAL DRUGS: ☐NEVER ☐QUIT - How Long Ago? _____ Type _____

☐ CURRENT USE - Type _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

☐ DIABETES: Type 1 or Type 2 ☐ CANCER
☐ HIGH BLOOD PRESSURE ☐ CORONARY ARTERY DISEASE ☐ HEART DISEASE
☐ RHEUMATOID ARTHRITIS ☐ BLEEDING DISORDER ☐ STROKE
☐ OTHER

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YOUR MEDICAL HISTORY

Allergies: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

☐ NONE KNOWN

Reaction: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/Aids	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	High cholesterol	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Kidney Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Liver Disease	Y	N	Stroke	Y	N
Cancer	Y	N	Low Blood Pressure	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Migraine Headaches	Y	N	Tuberculosis	Y	N
If Yes, Type 1 or Type 2 (Circle)			Mitral Valve Prolapse	Y	N			
Other Conditions:								

CURRENT PROBLEM

What specific problem brings you in to our office today? _____

_____

How long ago did this problem start? _____Days/Weeks/Months/Years

Did your pain problem: □ Begin suddenly □ Gradually develop over time

How would you describe your pain or symptom?

☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

Since the time your pain or problem began, has it: ☐ Stayed the Same ☐ Become Worse ☐ Improved

What makes your pain or problem feel worse?

☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress Shoes

☐ High Heels ☐ Flat Shoes ☐ Any Closed Toe Shoe ☐ Running ☐ Other

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

Was this problem caused by an injury? □ Yes □ No Describe _____

If yes, was it a work-related injury? □ Yes □ No

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E-PRESCRIBING CONSENT

E-Prescribing is defined by a physician's ability to electronically send an accurate, error free and understandable prescription directly to your pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act 2003 listed standards that must be included in an E-Prescribing program. These include: (1) Formulary and benefit transactions, which gives the prescriber information about which drugs are covered by a drug e-benefit plan; (2) Medication history transactions, which provides the physician with information about medications the patient is already taking to minimize adverse drug events.

I authorize **ADVANCED FEET & ANKLE CARE**, division of NJPPSG, to view my external prescription history via electronic e-prescribing services. I understand that prescription history from multiple, other unaffiliated providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of **ADVANCED FEET & ANKLE CARE**, division of NJPPSG, and it may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions. If applicable, I understand my prescription history will become part of my record at this practice. Understanding all of the above, I hereby provide informed consent to **ADVANCED FEET & ANKLE CARE**, division of NJPPSG, to enroll me in the e-prescribe program. This consent will remain enforced until revoked or changed.

PATIENT SIGNATURE _____ PARENT/LEGAL GUARDIAN SIGNATURE _____

I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I give permission to the doctors at **ADVANCED FEET & ANKLE CARE**, a division of New Jersey Podiatric Physicians and Surgeons Group, LLC, to administer and perform any diagnostic therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and/or treatment of my condition.

Patient/Minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, caretaker, or friend, over the age of 18 will be present, written consent from the parent/legal guardian stating as such must be presented at the time of the appointment. Thank You.

PRINT NAME OF PATIENT _____ PRINT PARENT/LEGAL GUARDIAN _____

PATIENT SIGNATURE _____ PARENT/LEGAL GUARDIAN SIGNATURE _____

DATE _____

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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgement of Practice's Notice of Privacy Practices:**
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ _____
Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian**

II. **Designation of Certain Relatives, Close Friends, and other Caregivers as my Personal Representative:**
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Relation: _____

Print Name: _____ Relation: _____

Print Name: _____ Relation: _____

III. **Request to Receive Confidential Communications by Alternative Means:**
As provided by Privacy Rule Section I64.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

_____ _____
Home Telephone Number **Written Communication Address**

_____ OK to leave message with detailed information _____ OK to mail to address listed above
_____ Leave message with call back numbers only _____ E-mail me at: _____

_____ _____
Work Telephone Number **Fax Number**

_____ OK to leave message with detailed information _____ OK to Fax to number listed above
_____ Leave message with call back numbers only _____ E-mail me at: _____

Other: _____

_____ _____
Name of Patient **Signature of Patient/Parent/Guardian**

_____ _____
Witness Signature **Date**

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FINANCIAL POLICY FOR ADVANCED FEET & ANKLE CARE

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan, we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may
have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/ AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections with interest accruing on balance. It is also your responsibility to pay for the interest accrued if sent to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check, or Credit Card. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. If your insurance company should happen to send payment to you, the patient, we expect you would forward it to our office to be applied to your balance.
I have read the above policy regarding my financial responsibility to Advanced Feet & Ankle Care for medical services provided. I agree to pay Advanced Feet & Ankle Care any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Advanced Feet & Ankle Care, division of New Jersey Podiatric Physicians & Surgeons Group, all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT patient name: _____ **Signature:** _____

FINANCIALLY RESPONSIBLE PARTY

PRINT name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____

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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 a stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these simple 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:** _____

Select "YES" OR "NO"

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 (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: _____ **Date:** _____

Physician Signature: _____

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Please Answer the Following Required Questions

Date: _____

Patient Name: _____

Height: _____

Weight: _____

Did you have a flu shot? YES NO

If yes, date: _____

Did you have a pneumonia vaccine? YES NO

If yes, date: _____

Do you smoke? YES NO

Patient Signature: _____