

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/____ AGE: ____ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-____ YES NO

WORK PHONE #: (____) ____-____ YES NO

CELL PHONE #: (____) ____-____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

RACE: _____ ETHNICITY: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-____

PRIMARY CARE DOCTOR: _____ PHONE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
____ YES NAME(S) _____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

WHO REFERRED YOU TO US? _____

EMPLOYER: _____ OCCUPATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

ADVANCED ANKLE AND FOOT CENTER, LLC

1259 US 46 – BUILDING 3
PARSIPPANY, NJ 07054
973-263-5500
WWW.ADVANCEDFOOTCENTER.ORG

561 EAST 28TH STREET
PATERSON, NJ 07504

220 HAMBURG TURNPIKE
SUITE 14
WAYNE, NJ 07470

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

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

HEIGHT _____ **WEIGHT** _____ **SHOES SIZE** _____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF 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 _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES: TYPE 1 OR TYPE 2 CANCER HEART DISEASE
 HIGH BLOOD PRESSURE STROKE CORONARY ARTERY DISEASE THYROID DISEASE
 RHEUMATOID ARTHRITIS
 OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS _____ NONE KNOWN
 ANESTHESIA _____ FOODS _____
 TAPE LATEX SHELLFISH IODINE OTHER _____

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	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS: _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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561 EAST 28TH STREET

220 HAMBURG TURNPIKE

PARSIPPANY, NJ 07054

PATERSON, NJ 07504

SUITE 14

973-263-5500

WAYNE, NJ 07470

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DATE OF BIRTH: ____/____/____

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT 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 ANKLE AND FOOT CENTER, 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.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARE TAKER 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

SIGNATURE PARENT/LEGAL GUARDIAN

E-PRESCRIBING CONSENT

E-PRESCRIBING IS DEFINED BY A PHYSICIANS 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 HAVE TO 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 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 ANKLE AND FOOT CENTER, 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 ANKLE AND FOOT CENTER, 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 THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE.

UNDERSTANDING ALL OF THE ABOVE, I HERBY PROVIDE INFORMED CONSENT TO ADVANCED ANKLE AND FOOT CENTER, TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

PATIENT SIGNATURE

PARENT/LEGAL GUARDIAN SIGNATURE

DATE