MEDICAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present Health or Cause of Death	MOTHER	Present Health or Cause of Death	SPOUSE	Present Health or Cause of Death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		HOW MANY DECEASED		CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH		HOW MANY DECEASED		CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH		HOW MANY DECEASED		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

5 MEDICAL HISTORY

Check (✓) symptoms you currently have or have had in the past year. (All information is strictly confidential)

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____)_____

List allergies to medications or substances _____

_____

_____

HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other_____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

6 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed by — Date

Princeton Foot and Ankle Associates, PC
Medical and Surgical Treatment of the Foot and Ankle

Dr. Josh B. Ottenheimer
Dr. Peter Panagakos
Dr. Sachin H. Patel

11 North Harrison Street, Princeton, NJ 08540
P: 609-924-1922. F: 609-497-2936

263 Princeton-Hightstown Road, West Windsor, NJ 08550
P: 609-799-0043. F: 609-799-0047

OFFICE POLICIES

Welcome to our practice. It is an honor to care for you and your family. Please take a few minutes to review this document and sign where indicated. We are glad to answer any questions regarding our office policy.

APPOINTMENTS

Documentation: Our office needs certain documentation to serve you (i.e. insurance card, referral, driver's license, and any changes to your personal information, address, and phone number) it is necessary to have this documentation with you at the time of your visit. Not having proper documentation may cause you to be financially responsible for your office visit.

Minors: Children under 18 must be accompanied by a parent or legal guardian who has appropriate documentation, such as written parental permission. Our staff is not permitted to watch your child while you are receiving care at the practice.

BILLING

Patient Financial Responsibility: Payments for copays, deductibles, as set forth by your insurance company are due at the time of your service. Any coinsurance, deductibles, or non-covered services as determined by your BENEFIT PLAN will be billed to you and are due upon receipt. **In the event that your bill goes to our collection agency you will be responsible for your balance and all fees are assessed by the collection agency.** Please understand that while your insurance may confirm your benefits, as per the insurance company guidelines confirmation of benefits is not a guarantee of payment and you will be responsible for any unpaid balance. Deductibles cannot be legally written off. You have a contract with your insurance company that once you pay the deductible they will then pick up their percentage and you are then responsible for your deductible and any additional co-insurance that is due.

TIER II INSURANCE: WE ARE TIER II WITH **OMNIA INSURANCE.** TIER II HAS A HIGHER DEDUCTIBLE AND THEY COVER AT A LOWER PERCENTAGE, WHICH IS A HIGHER RESPONSIBILITY FOR THE PATIENT.

Payment Methods: We accept cash, personal checks, Visa, Mastercard, American Express, and Discover. You can also pay online through our patient portal.

Returned Checks: There will be a $30.00 fee for each check not honored by your financial institute.

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X-RAYS/MRI/OTHER STUDIES

Pre-Certification: Prior to scheduling an appointment per RX, insurance precertification may be required. Your insurance company may not pay for your testing, if you don't have their required precertification approval. As a result, it may take 7-10 business days to accomplish/finalize this task. Our office does everything so we can expedite the process. We will contact you as soon as we have the Authorization.

COPIES OF MEDICAL RECORDS/X-RAYS/FORM COMPLETION

Release of X-Rays: We may provide you, another provider, or third party with a copy of your X-ray for consultation, further diagnostic testing, or other procedure. You can request copies by completing our medical record release form. In certain circumstances, you may incur a cost of $10.00 for a CD of your X-ray.

Copies of Medical Records: Original medical records are the property of the provider. Copies can be reproduced for a charge of $1.00 per page, but no more than $100.00 for the complete copy.

PRESCRIPTIONS

Please call for a refill before you run out of your medication. We may not refill prescriptions if you are overdue for your office visit. It may take up to 48 hours for a refill approval and fulfillment. Many narcotics can't be refilled over the phone; you may be required to come to the office in person to pick up your prescription. Due to legal and regulatory guidelines, we may not be able to issue replacement for narcotic medication that you have lost.

NON-REFUNDABLE - All Durable Medical Equipment (DME)

i.e. custom orthotics, power-steps, walking boots, toe wedges, etc. are non-refundable.

ACKNOWLEDGEMENT and AGREEMENT to the terms and conditions of this document

_____

Patient's Name Date

_____

Patient's/Parent/Guardian Signature

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- May we phone email or send a text to you to confirm appointments? YES NO
- May we leave a message on your answering machine at home or on your cell phone? YES NO
- May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

Signature: _____ Date: _____

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Princeton Foot and Ankle Associates

HIPAA

HIPAA is a federal government regulation which contains rules about how we can use your medical information with, and without, your prior permission. It also gives patients new rights with respect to the privacy of their medical information. We are obligated by law to make available to you a Notice of Privacy Practices which explains our duties and your rights, and to get a written acknowledgement from you that you have received this information. It is therefore necessary for you to sign this form below and we ask your cooperation in this regard. To learn more about HIPAA, you may visit the United States Department of Health and Human Services' website at:

http://www.hhs.gov/hipaa/

_____ I understand a copy of Princeton Foot and Ankle Associates' Notice of Privacy Practice is available for my review.

Name (sign): _____

Name (print): _____ Date: _____