FAMILY FOOT & ANKLE CENTERS OF SOUTH JERSEY
496 N. KINGS HIGHWAY, SUITE 210
CHERRY HILL, NJ 08034
PHONE: (856) 667-8222 FAX (856) 667-9739

JOSEPH L. DIMENNA, DPM, FACFAS
DAVID V. DIMENNA, DPM, FACFAS
JOSEPH V. BAKANAS, DPM

PATIENT INFORMATION FORM

NAME: _____
LAST FIRST MI

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE (home): _____ PHONE (work): _____ PHONE (cell): _____

SS#: _____ MARITAL STATUS: _____ RACE: _____ AGE: _____ BIRTHDATE: _____

SHOE SIZE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

GENDER IDENTITY: _____

OCCUPATION: _____ EMAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

PRIMARY CARE/REFERRING PHYSICIAN: _____ PHONE: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: _____

SECONDARY MEDICAL INSURANCE: _____

NAME OF INSURANCE SUBSCRIBER: _____ DATE OF BIRTH: _____

IS THIS A WORK RELATED INJURY? YES NO DATE OF INJURY: _____ EMPLOYER PHONE: _____

EMPLOYER NAME AND ADDRESS: _____

_____

ADJUSTER NAME: _____ PHONE: _____

CLAIM #: _____ CLAIMS ADDRESS: _____

MOTOR VEHICLE ACCIDENT: (CIRCLE) YES NO DATE OF ACCIDENT: _____ DRIVER / PASSENGER

OTHER: _____

The undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, or for services rendered, without obtaining my signature on each and every, claim to be submitted for myself and/or my dependents. I acknowledge that this signature will bind me as though the undersigned had personally signed the particular claim. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the information above is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

I _____ hereby authorize my insurance company to pay and assign all benefits directly to FAMILY FOOT AND ANKLE CENTER OF SOUTH JERSEY for services provided. I understand that I will be responsible for any co-payments, deductible, non-covered or unauthorized services, or any services provided after my coverage ceases to be effective. I further acknowledge that any insurance benefits, when received by and paid to FAMILY FOOT AND ANKLE CENTER OF SOUTH JERSEY will be credited to my account, in accordance with the above assignment.

_____ _____
(Authorized signature) **(Date)**

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MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

WHAT FOOT OR ANKLE PROBLEM CURRENTLY CONCERNS YOU? _____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING: (CIRCLE) PAIN BURNING NUMBNESS IN FEET NIGHT CRAMPS

DIFFICULTY WALKING OTHER: _____

IS THERE A FAMILY HISTORY OF FOOT PROBLEMS? _____

HAVE YOU SEEN A PODIATRIST BEFORE? _____ IF SO, WHEN? _____

ARE YOU IN GOOD HEALTH?_____ DO YOU EXERCISE? _____ HOW OFTEN? _____

WHAT TYPE OF EXERCISE DO YOU DO? _____

DO YOU SMOKE? YES NO HOW MUCH?_____ FOR HOW LONG?_____

DO YOU CONSUME ALCOHOL? YES NO HOW MUCH?_____ HOW OFTEN?_____

DO YOU USE /TAKE ILLEGAL DRUGS/NARCOTICS? YES NO HOW MUCH?_____ HOW OFTEN?_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING? POOR VISION POOR HEARING

DO YOU HAVE: LANGUAGE BARRIERS RELIGIOUS/CULTURAL BARRIERS

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE? YES NO

HAVE YOU BEEN TOLD THAT YOU HAVE OR HAD ANY OF THE FOLLOWING:

_____ DIABETES	_____ BLOOD CLOTS	_____ STROKE
_____ HIGH BLOOD PRESSURE	_____ KIDNEY DISEASE	_____ CANCER
_____ BLEEDING DISORDERS	_____ HEART DISEASE	_____ STOMACH ULCERS
_____ POOR CIRCULATION	_____ LIVER DISEASE	_____ ARTHRITIS

_____ OTHER _____

WHAT OPERATIONS/SURGERIES INCLUDING FOOT/ANKLE SURGERY HAVE YOU HAD AND WHEN?

_____

_____

_____

I certify that the information above is true and correct to the best of my knowledge. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice.

_____ _____

(Authorized signature) (Date)