Garden State

WELCOME TO OUR OFFICE
PLEASE PRINT THE FOLLOWING INFORMATION
THANK YOU

DATE: _____/_____/_____

PATIENT NAME: _____
LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER: _____/_____/_____ D.O.B: _____/_____/_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GENDER: ☐ **Male** ☐ **Female** **MARITAL STATUS:** ☐ **Single** ☐ **Divorced** ☐ **Married** ☐ **Widowed**

PRIMARY LANGUAGE SPOKEN IN THE HOME: _____

ETHNICITY: ☐ **Hispanic or Latino** ☐ **Not Hispanic nor Latino**

RACE: ☐ **White** ☐ **Black/African American** ☐ **Asian** ☐ **American Indian**

☐ **Alaska Native** ☐ **Native Hawaiian** ☐ **Pacific Islander Other:_____**

PHONE NUMBERS:
HOME _____/_____/_____
WORK _____/_____/_____
CELL _____/_____/_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT NAME & PHONE # _____

WORK STATUS: ☐ **Full time** ☐ **Part Time** ☐ **Retired** ☐ **Student**

EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU TO OUR OFFICE: _____

NAME OF PRIMARY INSURANCE: _____

NAME OF SECONDARY INSURANCE: _____

POLICY HOLDER NAME: _____
(IF NOT YOURS)

POLICY HOLDER DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO POLICY HOLDER_____

Garden State Foot & Ankle Specialists

Richard L. Corbin, DPM, FACFAS
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

Daniel J. Roche, DPM, FACFAS
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

Samantha L. Sheppard, DPM, FACFAS
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

Michael Kaminksy, DPM, AACFAS
Associate, American College of Foot & Ankle Surgeons

Patient Name: _____ **Today's Date:** _____

Reason for today's visit: _____

Allergies to medication/latex: _____

Current medications: _____

_____

_____

Past Medical History, Medical Conditions:

_____

Past Surgical History: _____

Family Medical History of Cancer, Heart Disease, Diabetes or other medical conditions

Father: _____
Mother: _____
Brother: _____
Sister: _____

Shoe Size:_____ **Height:**_____ **Weight:**_____

Pharmacy (Name/City):_____

Do you smoke cigarettes (circle): Yes No Previous – Stop ____ months/years ago

- How many packs per day: _____ For how many years: _____

Do you drink alcohol (circle): Never Occasionally Daily

Patient Signature: _____

1250 Park Avenue, Plainfield, NJ 07060 P: 908-755-0707 F: 908-755-9204
2253 South Avenue, Suite 1, Scotch Plains, NJ 07076 P: 908-233-1903 F: 908-233-1909
28 Millburn Avenue, Suite2, Springfield, NJ 07081 P: 973-379-9333 F: 973-218-1668
4 Progress Street, Edison, NJ 08820 P: 908-753-0500 F: 908-753-0199
1000 Route 9N, Suite 106, Woodbridge, NJ 07095 P: 732-636-8500 F: 732-636-8501
623 N. Wood Avenue, Suite 3, Linden, NJ 07036 P: 908-925-1444 F: 908-925-3728

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ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided an opportunity to read (if I chose to) a copy of the notice of Privacy Practices and understood the notice.

_____ _____

Patient Name (please print) Date

_____

Parent of Authorized Representative (if applicable)

_____

Signature

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INSURANCE

Although I have health insurance, I am aware that this is no guarantee of payment. If my insurance company denies payment, I understand that I am ultimately responsible for this bill.

If my insurance requires a referral, it is solely my responsibility to obtain the referral before my office visit. If I do not obtain the referral prior to the visit, payment for the visit is my responsibility.

I am responsible to notify the office of any and all changes in my health insurance and present updated cards in coordination. If I do not provide accurate information, I am responsible for payment of office visit.

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

_____
Print Patient Name

_____
Patient Signature or Responsible Party

_____
Date

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HIPAA Consent Form

I, _____, understand that under the Health Portability and Accountability Act 1996 (HIPAA) I have certain rights to privacy regarding my health information. I also understand that Garden State foot & Ankle Specialist originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for future care and treatment at Garden State foot & Ankle Specialist.
I understand that this information can be used as:

- A basis for planning my care and treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- A means of communication among the many health professionals who contribute to my care.
- A means by which a third-party payer can verify that services billed were actually provided and obtain payment from third party payers.
- A tool for routine healthcare operations such as assessing quality and receiving the competence of healthcare professionals.

I prefer to have notification of my healthcare information by the following methods. Please check all applicable:
_____ Home telephone
_____ If I am not available, you may leave a message with a family member
_____ Detailed message on answering machine
_____ Work phone with direct contact only
_____ Cell phone

My health information may also be discussed with the following people upon their request:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature Date