

Complete Foot and Ankle, LLC



Dr. Jacob Reinkraut, D.P.M.
Dr. Danny Gomez, D.P.M.
Dr. Michelle Suh, D.P.M.

400 Route 17 South
Ridgewood, NJ 07450
Tel: (201) 445-2288
Fax: (201) 445-2288

210 Passaic Street
Garfield, NJ 07026
Tel: (201) 445-2288
Fax: (201) 445-2288

Last Name: _____ First Name: _____
Street: _____ Apt/Box: _____
City: _____ St: _____ Zip: _____
Phone :() _____ SSN: _____ - _____ - _____
Cell :() _____ Work: () _____
Gender M/ F DOB: ____/____/____ Age: _____ Height: _____ Weight: _____ Shoe Size _____
Patient's Marital Status _____ Email Address: _____
Race: _____ Ethnicity: _____
Patient Employer: _____ Patient Occupation: _____
Sports, Activities or Hobbies: _____
**** How were you referred to this office? _____

Primary Physician: _____ Phone :() _____
Town/State: _____ Date of Last Visit: _____
Pharmacy: _____ Town: _____ Phone :() _____
In case of an Emergency please notify: _____ **Tel:** () _____

Have you or any of your family members been treated for diabetes? _____ If yes, who? _____
List any medical conditions you have: _____

Have you had any injuries or operations on your feet or legs? _____
What is the main reason for your visit today? _____
How long have you had these symptoms? _____
Please Rate the Pain Level None or 1 to 10 _____
What have you done to address the problem? _____

Tobacco Use (*Please circle*): Yes No Former Smoker

How many packs per day? _____

Alcohol Use (*Please circle*): Yes No

If yes, Describe: Rarely Moderately Daily

If Daily, how much a day? _____

Patient Name _____ Date _____

PAST SURGICAL HISTORY:

Previous Hospitalizations/ Surgeries/ Serious Illnesses	When	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS

Allergic / Immunologic:

YES NO

- Aspirin or Other Pain Remedies
- Iodine, Merthiolate or Other Antiseptic
- Latex
- Morphine, Demerol or other Narcotics
- Novocain or other Anesthetics
- Penicillin or Other Antibiotics
- Tetanus Antitoxin or Other Serums

Other Drugs/Medication Allergies:

Known Food Allergies:

Environmental Allergies:

MEDICATIONS

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

	Age	Disease(s)	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling(s)	_____	_____	_____
Children	_____	_____	_____

I HEREBY GIVE PERMISSION TO JACOB REINKRAUT, DPM AND OR ASSOCIATES FOR THE EXAMINATION AND RENDERING CARE FOR MY FOOT/ANKLE PROBLEM AND/OR RELATED CONDITION. TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR'S OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE: _____ DATE: _____

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PATIENT INFORMATION:

SEX: MALE FEMALE

BIRTH DATE: ____/____/____

SOCIAL SECURITY# ____-____-____

LAST NAME: _____

FIRST NAME: _____ M.I. _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____

WORK PHONE: (____) _____

CELL PHONE (____) _____

INSURED'S INFORMATION

EMPLOYER OF INSURED: _____

YOUR RELATIONSHIP TO INSURED:

SELF SPOUSE CHILD OTHER

INSURED PERSON: MALE FEMALE

INSURED'S NAME (if other than self): _____

LAST NAME: _____

FIRST NAME: _____ M.I. _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____

WORK PHONE: (____) _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: ____ / ____ / ____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____
IDENTIFICATION # _____ Group # _____

SECONDARY INSURANCE NAME: _____
IDENTIFICATION # _____ Group # _____

AUTHORIZATION / RESPONSIBILITY AGREEMENT:

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. JACOB REINKRAUT DPM, AND / OR ASSOCIATES AND WILL BE RESPONSIBLE FOR THE REMAINING BALANCE. A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE TO PAY MY ACCOUNT AS SERVICES ARE PROVIDED. HOWEVER, IF I AM NOW OR IN THE FUTURE BECOME A MEMBER OF AN HMO OR MANAGED CARE PLAN, I WILL PROVIDE PROPER AUTHORIZATION OR REFERRALS FOR THIS AND UPCOMING VISITS. SHOULD MEDICAL CARE BE GIVEN AND PROPER AUTHORIZATION OR REFERRAL NOT OBTAINED, I AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO COMPLETE FOOT AND ANKLE, LLC.

UNDER CERTAIN CIRCUMSTANCES, I MAY HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF; I CLEARLY UNDERSTAND THAT THE BILL IS STILL MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS). IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I AGREE TO PAY PROMPTLY. ANY OUTSTANDING BILLS MAY BE SENT TO A BILLING AGENCY AND A 15% SERVICE FEE WILL BE ADDED.

SIGNED: _____ DATE: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I may request a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Patient or Authorized Representative (if applicable)

Signature

SIGNATURE ON FILE

Patient's Name (print)

Insured/Medicare Number

I request that payment of authorized insurance and Medicare benefits be made either for me or on my behalf to Jacob Reinkraut, D.P.M and/or Associates for any services furnished to me by him and or associates. I authorize any holder of medical information concerning me to release to my Insurance carrier or the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits to related services.

Signature of Patient

Date

Yearly renewal of signature on file as described above

Signature of Patient

Date

Signature of Patient

Date