Complete Foot and Ankle, LLC

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 OFFFICE 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