SOMERSET FOOT AND ANKLE

DEMOGRAPHICS

Patient Name: _____ Patient D.O.B:_____
Sex At Birth: (M__) (F___) Current Gender Identity: _____
Preferred Name: _____ Occupation: _____
Marital Status: (S__) (M__) (D__) (W__) (Other__) Spouse's Name: _____
Ins. Policy Holder(Spouse, Parent, Self): _____ Insured D.O.B:_____
Address: _____ Apt #: _____ City: _____
State: _____ Zip Code: _____
Cell Phone: _____ Home Phone: _____
Preferred Method of Contact: (Cell___) (Home___)
EMERGENCY CONTACT
Name:_____ Phone Number: _____
Relationship to patient: _____
Primary Care Doctor: _____ Last Visit: _____
Preferred Pharmacy:_____ Pharmacy Location: _____

*HMO/PPO Signature on File: I request that payment of authorized benefits be made to Somerset Foot and Ankle for services furnished to me by that physician. I authorize any holder of medical information about me to release to my insurance company or its agents any information needed to determine these benefits or the benefits payable for related service.
Signature: _____ Date: _____

*Medicare Universal Signature on File: I request payment of authorized Medicare benefits to be made to Somerset Foot and Ankle for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare and its agents any information needed to determine these benefits payable for related services.
Signature: _____ Date: _____

*Secondary Insurance Signature on File: I request payment of authorized benefits to be made to Somerset Foot and Ankle for any services furnished to me by that physician. I authorize any holder of Medicare and medical information about me to release to my insurance company and its agents for any information needed to determine these benefits or the benefits payable for related services.
Signature: _____ Date: _____

*I hereby give permission to Dr. Robert Thiele/Dr. Prashant Bhoola to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis/treatment of my foot/feet condition(s).
Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Print Name: _____

Signature: _____Date: _____

********** For Office Use Only **********

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- The individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please specify):

SOMERSET FOOT AND ANKLE

PATIENT CONFIDENTIALITY FORM

Patient Name: _____ D.O.B: _____

Patient confidentiality is of great concern to our office. Please indicate below with whom and where we may leave a message. Please be aware that any phone messages may not be on secure lines.

MAY WE LEAVE A MESSAGE AT:

Home #: _____ YES NO

Cell #: _____ YES NO

In the event a family member, friend, or relative contacts our office, please list with whom we have permission to discuss your care.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please be aware that Somerset Foot and Ankle will obtain a list of your medications prescribed by outside physicians/facilities via our electronic prescription program and/or your medical records.

Signature: _____ Date: _____

SOMERSET FOOT AND ANKLE

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices.

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that notice for further information.

Uses and Disclosures of Health Information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on your Authorization: Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization: In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health safety.
- To Government agencies for purposes of their audits, investigations and other oversight activities.
- To Government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or ingredients.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas, and as otherwise required by law.

Patient Rights: As our patient, you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive notice of our privacy practices.

9 Monroe Street
Bridgewater Township, NJ 08807
P: (908) 231-1114 F: (908) 252-1930

SOMERSET FOOT AND ANKLE

PATIENT MEDICAL HISTORY FORM

DATE:_____

PATIENT NAME:_____ D.O.B:_____

PREFERRED NAME:_____ SHOE SIZE: _____ (MENS / WOMANS)

SEX AT BIRTH: (M___) (F___) CURRENT GENDER IDENTITY:_____

BRIEFLY DESCRIBE YOUR SYMPTOMS AND DURATION:

_____

_____

_____

LIST ANY PREVIOUS TREATMENTS FOR THE ABOVE PROBLEM:_____

_____

DRUG ALLERGIES: ☐ YES ☐ NO

PLEASE LIST ANYTHING THAT YOU ARE ALLERGIC TO. (I.E.: *ANTIBIOTICS/PENICILLIN, NOVOCAINE/ANESTHETICS, TAPE, IODINE, CORTISONE, LATEX, ETC.*): _____

_____

HAVE YOU HAD ANY ADVERSE REACTIONS TO INJECTIONS? : ☐ YES ☐ NO

CURRENT MEDICATIONS

PLEASE LIST ANY MEDICATIONS THAT YOU ARE NOW TAKING. INCLUDE NON-PRESCRIPTION MEDICATIONS & VITAMINS OR SUPPLEMENTS.

PLEASE INCLUDE **NAME OF DRUG, DOSE**(INCLUDE STRENGTH & NUMBER OF PILLS PER DAY) **AND MEDICATION DURATION**

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
9._____ 10._____

SOCIAL HISTORY

SMOKING: ☐ YES ☐ NO PACKS PER DAY:_____ YEARS:_____ QUIT/WHEN? _____

ALCOHOL USE: ☐ YES ☐ NO DRINKS PER DAY:_____ YEARS:_____ QUIT/WHEN? _____

DRUG ABUSE: ☐ YES ☐ NO TYPE: PRESCRIPTION/ NON-PRESCRIPTION/ BOTH QUIT/WHEN? _____

CONTINUE ON BACK

SOMERSET FOOT AND ANKLE

PAST MEDICAL HISTORY

DO YOU NOW OR HAVE YOU EVER HAD:

- ☐ DIABETES(TYPE____)
- ☐ HIGH BLOOD PRESSUR
- ☐ HIGH CHOLESTEROL
- ☐ HYPOTHYROIDISM
- ☐ GOITER
- ☐ CANCER(TYPE_____)
- ☐ LEUKEMIA
- ☐ PSORIASIS
- ☐ ANGINA
- ☐ HEART PROBLEMS
- ☐ HEART MURMUR
- ☐ PNEUMONIA
- ☐ PULMONARY EMBOLISM
- ☐ ASTHMA
- ☐ EMPHYSEMA
- ☐ STROKE
- ☐ EPILEPSY(SEIZURES)
- ☐ CATARACTS
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ CROHN'S DISEASE
- ☐ COLITIS
- ☐ ANEMIA
- ☐ JAUNDICE
- ☐ HEPATITIS(TYPE_____)
- ☐ STOMACH/PEPTIC ULCER
- ☐ RHEUMATIC FEVER
- ☐ TUBERCULOSIS
- ☐ HIV/AIDS
- ☐ CURRENTLY PREGNANT
- ☐ CURRENTLY BREAST FEEDING

PLEASE LIST ALL PREVIOUS SURGERIES: _____

_____

HAVE YOU EVER HAD VASCULAR SURGERY? ☐ YES ☐ NO (IF YES, PLEASE EXPLAIN):_____

FAMILY HISTORY

	LIVING?	*AGE/S*	*HEALTH*	*IF DECEASED; CAUSE*
FATHER	☐ YES ☐ NO			
MOTHER	☐ YES ☐ NO			
SIBLINGS	☐ YES ☐ NO			
CHILDREN	☐ YES ☐ NO			

SYSTEMS REVIEW

IN THE PAST MONTH, HAVE YOU HAD ANY OF THE FOLLOWING ISSUES?

GENERAL
- ☐ RECENT WEIGHT GAIN; HOW MUCH_____
- ☐ RECENT WEIGHT LOSS; HOW MUCH_____
- ☐ FATIGUE
- ☐ WEAKNESS
- ☐ FEVER
- ☐ NIGHT SWEATS

NERVOUS SYSTEM
- ☐ HEADACHES
- ☐ DIZZINESS
- ☐ FAINTING SPELLS
- ☐ NUMBNESS/TINGLING
- ☐ MEMORY LOSS

VASCULAR
- ☐ PAIN IN LEGS WHEN WALKING
- ☐ SWELLING IN LEGS/FEET
- ☐ PAIN IN LEGS AT NIGHT
- ☐ COLD FEET
- ☐ SORES ON FEET
- ☐ WOUNDS? (WHERE _____)
- ☐ VARICOSE VEINS
- ☐ HAIR LOSS
- ☐ COLOR CHANGES OF HANDS/FEET

MUSCLE/JOINTS/BONES
- ☐ NUMBNESS
- ☐ JOINT PAIN
- ☐ MUSCLE WEAKNESS
- ☐ JOINT SWELLING(WHERE_____)

EARS
- ☐ LOSS OF HEARING

THROAT
- ☐ FREQUENT SORE THROATS
- ☐ HOARSENESS
- ☐ DIFFICULTY IN SWALLOWING
- ☐ PAIN IN JAW

PSYCHIATRIC ISSUES
- ☐ DEPRESSION
- ☐ ANXIETY

STOMACH/INTESTINES
- ☐ HEART BURN
- ☐ STOMACH PAIN
- ☐ VOMITTING
- ☐ INCREASING CONSTIPATION
- ☐ PERSISTENT DIARRHEA
- ☐ BLOOD IN STOOLS

HEART AND LUNGS
- ☐ CHEST PAINS
- ☐ PALPITATIONS
- ☐ SHORTHNESS OF BREATH
- ☐ FAINTING
- ☐ SWOLLEN LEGS/FEET
- ☐ COUGH

EYES
- ☐ LOSS OF VISION
- ☐ DOUBLE OR BLURRED VISION

SKIN
- ☐ REDNESS
- ☐ RASH
- ☐ NODULES/BUMPS

KIDNEY/URINE/BLADDER
- ☐ FREQUENT/PAINFUL URINATION
- ☐ BLOOD IN URINE

OTHER MEDICAL CONDITIONS: _____

_____