

PATIENT INFORMATION FORM

(PLEASE PRINT CLEARLY)

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

AGE: ___ SEX: M F PRIMARY LANGUAGE: _____ RACE: _____ ETHNICITY: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____

EMAIL ADDRESS: _____ (WILL NOT BE SHARED)

EMPLOYER: _____ WORK PHONE: (____) _____ - _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: (____) _____ - _____

PRIMARY CARE DOCTOR: _____ DATE LAST SEEN _____

PHONE: (____) _____ - _____ ADDRESS: _____ CITY/STATE: _____

PHARMACY: _____ LOCATION: _____ PHONE: (____) _____ - _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE: (____) _____ - _____ WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE: (____) _____ - _____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

ID # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE: (____) _____ - _____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

ID # _____ GROUP # _____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

<u>MEDICATION NAME</u>	<u>DOSE</u>	<u>HOW OFTEN DO YOU TAKE?</u>

PLEASE LIST ALL PRIOR SURGERIES:

<u>TYPE OF SURGERY</u>	<u>DATE</u>	<u>TYPE OF SURGERY</u>	<u>DATE</u>

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

<u>REASON FOR HOSPITALIZATION</u>	<u>DATE</u>	<u>REASON FOR HOSPITALIZATION</u>	<u>DATE</u>

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS _____
 ANESTHESIA _____ FOODS _____
 TAPE LATEX SHELLFISH IODINE OTHER _____
 NONE KNOWN

REACTION: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? Y=YOURSELF M=MOTHER F=FATHER

ACID REFLUX	Y	M	F	FIBROMYALGIA	Y	M	F	NEUROPATHY	Y	M	F
ANEMIA	Y	M	F	GOUT	Y	M	F	OPEN SORES	Y	M	F
ARTHRITIS	Y	M	F	HEART ATTACK	Y	M	F	PNEUMONIA	Y	M	F
ASTHMA	Y	M	F	HEART DISEASE/FAILURE	Y	M	F	POLIO	Y	M	F
BACK TROUBLE	Y	M	F	HEPATITIS	Y	M	F	RHEUMATIC FEVER	Y	M	F
BLADDER INFECTIONS	Y	M	F	HIV+/AIDS	Y	M	F	SICKLE CELL DISEASE	Y	M	F
ABNORMAL BLEEDING	Y	M	F	HIGH BLOOD PRESSURE	Y	M	F	SKIN DISORDER	Y	M	F
BLOOD CLOTS	Y	M	F	KIDNEY DISEASE	Y	M	F	SLEEP APNEA	Y	M	F
BLOOD TRANSFUSION	Y	M	F	LIVER DISEASE	Y	M	F	STOMACH ULCERS	Y	M	F
BRONCHITIS/EMPHYSEMA	Y	M	F	LOW BLOOD PRESSURE	Y	M	F	STROKE	Y	M	F
CANCER	Y	M	F	MIGRAINE HEADACHES	Y	M	F	THYROID DISEASE	Y	M	F
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	M	F	MITRAL VALVE PROLAPSE	Y	M	F	TUBERCULOSIS	Y	M	F
OTHER CONDITIONS:											

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

PLEASE REVIEW THE FOLLOWING CAREFULLY AND CIRCLE ANY SYMPTOMS THAT YOU MAY BE EXPERIENCING

CONSTITUTIONAL: APPETITE DECREASE, APPETITE INCREASE, CHILLS, DIZZINESS, HEADACHES, HOT FLASHES, MIGRAINE, NIGHT SWEATS, THIRST, VERTIGO, WEIGHT GAIN, WEIGHT LOSS

CARDIOVASCULAR: ANKLE SWELLING, CALF-CRAMPING, CHANGE IN TEMP OF EXTREMITY, COLD FEET, MURMUR, PACEMAKER, VARICOSITIES

ENDOCRINE: COLD INTOLERANCE, CUTS TAKE TOO LONG TO HEAL, DRY HAIR, DRY SKIN, HEAT INTOLERANCE, HYPERGLYCEMIA, HYPOGLYCEMIA

EAR, NOSE, MOUTH, THROAT: BLEEDING GUMS, BLOODY NASAL DISCHARGE, COUGH, DIFFICULTY W/ HEARING, DRY THROAT AND/OR MOUTH, LOST SENSE OF SMELL, PAINFUL TEETH, POST-NASAL DRIP, RINGING IN EARS, RUNNY NOSE, TINNITUS

EYES: BLURRED VISION, DISCHARGE, DRY EYES, EXCESS TEARING/WATERING, ITCHY EYES, PAIN OR SORENESS IN OR AROUND THE EYES, PHOTSENSITIVITY, REDDENED EYE(S)

NEXT PAGE

GENTOURINARY: BLOOD IN URINE, BURNING W/ URINATION, DISCHARGE, FLANK PAIN, HERPES OUTBREAK, IMPOTENCE, POLYURIA, URINARY FREQUENCY, URINARY INCONTINENCE, URINARY URGENCY

GASTROINTESTINAL: ABDOMINAL PAIN, ABDOMINAL DISTENTION, BLOOD IN STOOL, CONSTIPATION, DIARRHEA, EXCESS GAS, HEARTBURN, NAUSEA

IMMUNOLOGIC: ARTHRITIC FLARE UP, ASTHMA ATTACK RECENTLY, COUGHING, ENVIRONMENTAL/SEASONAL ALLERGIES, HAY FEVER SYMPTOMS

INTEGUMENTARY: BLISTERS, BURNING OF SKIN, DRY/SCALY SKIN, ECZEMA, HAIR LOSS, HYPERSENSITIVITY OF SKIN, HYPERTROPHIC SCARS, NON-HEALING WOUNDS, PSORIATIC FLARE UP, RASH, SUNBURN, TINGLING SENSATION

LYMPHATIC: ANEMIA, BLEEDING TENDENCY, BRUISE EASILY, FREQUENT NOSE BLEEDS, INCREASE TIME TO STOP BLEEDING, RECENT NIGHT SWEATS, SWOLLEN LYMPH NODES, WATER RETENTION

MUSCULAR/SKELETAL: ABDOMINAL PAIN, BACK PAIN, HIP PAIN, JOINT REDNESS, JOINT SWELLING, LEG CRAMPS, MORNING STIFFNESS, MUSCLE TENDERNESS, STIFFNESS, WEAKNESS

NEUROLOGICAL: BURNING, FACIAL TICK, HYPERSENSITIVITY, NUMBNESS, PARALYSIS, RECENT SEIZURE, TINGLING, TREMORS

PSYCHIATRIC: ADDICTION TO ALCOHOL, ANGER, ANXIOUSNESS, ATTEMPTED SUICIDE, CLAUSTROPHOBIC, DEPRESSION, DISORIENTATION, EMOTIONAL OR MENTAL ABUSE, IRRITABILITY, MEMORY LOSS, NIGHTMARES, OVERREACTING, PANIC ATTACKS, PARANOIA, POOR ANGER CONTROL

RESPIRATORY: BREATHING DIFFICULTY, CHEST PAIN W/ INSPIRATION, COLD-LIKE SYMPTOMS, FLU-LIKE SYMPTOMS, SLEEP APNEA, SNORING, WHEEZING

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

E-PRESCRIBING CONSENT

E-PRESCRIBING IS DEFINED BY A PHYSICIANS ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE, AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO YOUR PHARMACY. CONGRESS HAS DETERMINED THAT THE ABILITY TO ELECTRONICALLY SEND PRESCRIPTIONS IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY OF PATIENT CARE. E-PRESCRIBING GREATLY REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT 2003, LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AN E-PRESCRIBING PROGRAM. THESE INCLUDE: (1) FORMULARY AND BENEFIT TRANSACTIONS, WHICH GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY A DRUG BENEFIT PLAN; (2) MEDICATION HISTORY TRANSACTIONS, WHICH PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE ADVERSE DRUG EVENTS.

I AUTHORIZE (DR. DOUGLAS N. DELORENZO DPM), DIVISION OF NJPPSG, TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E-PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF (DR. DOUGLAS N. DELORENZO DPM), DIVISION OF NJPPSG, AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE PRESCRIPTIONS TO TREAT HIV, SUBSTANCE ABUSE AND PSYCHIATRIC CONDITIONS. IF APPLICABLE, I UNDERSTAND THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE. UNDERSTANDING ALL OF THE ABOVE, I HERBY PROVIDE INFORMED CONSENT TO (DR. DOUGLAS N. DELORENZO DPM), DIVISION OF NJPPSG, TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

PATIENT SIGNATURE

PARENT/LEGAL GUARDIAN SIGNATURE

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I GIVE PERMISSION TO THE DOCTORS AT (PRACTICE NAME), A DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS AND SURGEONS GROUP, LLC, TO ADMINISTER AND PERFORM ANY DIAGNOSTIC, THERAPEUTIC AND/OR OPERATIVE PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARE TAKER OR FRIEND, OVER THE AGE OF 18 WILL BE PRESENT; WRITTEN CONSENT FROM THE PARENT/LEGAL GUARDIAN STATING AS SUCH MUST BE PRESENTED AT THE TIME OF THE APPOINTMENT. THANK YOU.

PRINT NAME OF PATIENT

PRINT PARENT/LEGAL GUARDIAN

PATIENT SIGNATURE

SIGNATURE PARENT/LEGAL GUARDIAN

DATE

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections with interest accruing on balance. It is also your responsibility to pay for the interest accrued if sent to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: (~~CREDIT CARD, CASH OR CHECK~~). An additional \$25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to (~~Douglas N. DeLorenzo DPM LLC~~) for medical services provided. I agree to pay (~~Douglas N. DeLorenzo DPM LLC~~) any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to (~~Douglas N. DeLorenzo DPM LLC~~), division of New Jersey Podiatric Physicians & Surgeons Group, all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Douglas N. DeLorenzo, DPM and Associates

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient

Date of Birth

Signature of Patient/Parent/Guardian

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Relation _____

Print Name: _____ Relation _____

Print Name: _____ Relation _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: _____

Written Communication Address: _____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

____ OK to mail to address listed above

____ E-mail me at: _____

Work Telephone Number: _____

Fax Number: _____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

____ OK to Fax at the number listed above

____ E-mail me at: _____

Other: _____

Name of Patient (Printed)

Signature of Patient/Parent/Guardian

Witness signature

Date