



WEST MORRIS FOOT & ANKLE

Erato Giokas, DPM, AACFAS
Board Certified, American Board of Podiatric Medicine
Associate, American College of Foot & Ankle Surgery

DATE: _____

PATIENT NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: ___/___/___ SOCIAL SECURITY NUMBER: ___/___/___

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GENDER: Male Female
MARITAL STATUS: Single Married
 Divorced Widowed

PRIMARY LANGUAGE SPOKEN: _____

ETHNICITY: Hispanic or Latino Non Hispanic or Latino

RACE: White Black/African American
 Asian American Indian
 Alaska Native Native Hawaiian
 Pacific Islander Other: _____

PHONE NUMBERS: HOME: (___) - ___ - ___
CELL: (___) - ___ - ___
WORK: (___) - ___ - ___

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: _____ POLICY HOLDER DOB: ___/___/___

RELATIONSHIP TO POLICYHOLDER: _____



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Patient Name: _____ Today's date: _____

Reason for today's visit: _____

Allergies: _____

Current Medications:

Past Medical History: _____

Family Medical History:
Father: _____
Mother: _____
Brother(s): _____
Sister(s): _____

Social History:
Do you smoke cigarettes (circle): YES / NO Previous smoker? _____
How many packs per day? _____ For how many years? _____

Do you drink alcohol (circle) ? NEVER OCCASIONALLY DAILY
How many alcoholic drinks per week? _____

Shoe Size: _____ Height: _____ Weight: _____

Pharmacy Name: _____

Pharmacy Address: _____

Patient Signature: _____ Date: _____



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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 (print)

Date: _____

Parent of Authorized Representative (if applicable)

Signature



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INSURANCE

Although I have health insurance, I am aware that there 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 the payment of the 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 balance 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.

Patient name (Print)

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 my privacy regarding my health information. I also understand that West Morris Foot & Ankle originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatments and any plans for future care and treatment at West Morris Foot & Ankle.

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 communicating among the many health professionals who contribute to my care
- A means by which a third-party payor can verify that the 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
- Cell phone
- If I am not available you may leave a message with family member
- Detailed message on answering machine
- Work phone with direct contact only

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

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

Patient Signature: _____ Date: _____



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