

JERSEY FOOT & ANKLE CLINIC, LLC

Henrietta Obidigbo, D.P.M.

Podiatric Medicine and Surgery



(Welcome)

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you?

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____

3 CONTACT INFORMATION

Email _____

Home _____ Work _____ Ext _____

Mobile _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 PODIATRIC HISTORY

What is the chief complaint for which you to be treated (Include foot, ankle, knee hip, thigh complaints)

Have you ever been to a Foot Doctor before? Yes No
Name _____

Is there any personal or family history of diabetes? Yes No

Your Occupation _____

Cigarette/Tobacco use _____

Years Smoked _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

Ankle Pain _____ Athlete's Foot _____

Bunions _____ Corns & Callouses _____

Cramps or Numbness in Feet or Legs _____

Flat Feet _____ Foot or Leg Cramps _____

Heel Pain _____ Ingrown Toenails _____

Plantar's Warts _____ Tired Feet _____

Swelling in Ankles or Feet _____

5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	—	—	Diabetes	—	—	Psychiatric Care	—	—
Allergies to Anesthetics	—	—	Ear Problems	—	—	Radiation Treatment	—	—
Allergies to Medicine or Drugs	—	—	Epilepsy	—	—	Rash	—	—
Anemia	—	—	Eye Problems	—	—	Respiratory Disease	—	—
Angina	—	—	Fainting	—	—	Rheumatic Fever	—	—
Arthritis	—	—	Foot or Leg Cramps	—	—	Shortness of Breath	—	—
Artificial Heart Valves or Joints	—	—	Gout	—	—	Sinus Problems	—	—
Asthma	—	—	Headaches	—	—	Special Diet	—	—
Back Problems	—	—	Heart Disease	—	—	Stroke	—	—
Bleeding Disorders	—	—	Hemophilia	—	—	Swelling in Ankles, Feet	—	—
Cancer	—	—	Hepatitis or Jaundice	—	—	Swollen Neck Glands	—	—
Chemical Dependency	—	—	High Blood Pressure	—	—	Tired Feet	—	—
Chest Pain	—	—	Kidney Problems	—	—	Tuberculosis	—	—
Chronic Diarrhea	—	—	Liver Disease	—	—	Ulcers	—	—
Circulatory Problems	—	—	Low Blood Pressure	—	—	Varicose Veins	—	—
			Nervous Problems	—	—	Venereal Disease	—	—
			Phlebitis	—	—	Weight Loss, unexplained	—	—

Surgeries you have _____

Hospitalization other than for the surgeries listed _____

Family physician _____

Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? _____ Yes _____ No

If yes, please explain _____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins. _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? _____ Yes _____ No

7 ALLERGIES

Adhesive/Tape Local
 Anticoagulant Nov
 Therapy Penic
 Aspirin Seaf
 Codeine Sulf
 Demerol
 Iodine
 Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____

Date _____