Dr. Rosa C. Roman
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healthyfeetforlife.com

Ankle and Foot Center

NEW PATIENT FORM

FIRST NAME:	LAST NAME:			
DATE OF BIRTH:	TODAY'S DATE:	GENDER: M ◯	F ◯	
MARITAL STATUS: Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯		LANGUAGE:		
STREET ADDRESS :	APT #:	CITY:	STATE:	ZIP CODE:
EMAIL:	HOME PHONE #:	CELL PHONE #:		
OCCUPATION:	EMPLOYER:	ADDRESS:	WORK #:	
IF MINOR, PARENT'S NAME:		PARENT DOB:		
PARENT'S EMPLOYER:	ADDRESS:	WORK PHONE #:		
NAME OF SPOUSE:	DOB:	SPOUSE CELL #:		
SPOUSE'S EMPLOYER:	EMPLOYER ADDRESS:	BUSINESS PHONE #:		
EMERGENCY CONTACT AND PHONE #:	CONTACT RELATIONSHIP:			
PRIMARY INSURANCE:	SUBSCRIBER:	DOB:		
ID #:	GROUP#:			
SECONDARY INSURANCE:	SUBSCRIBER:	DOB:		
ID #:	GROUP#:			

- **I authorize the release of medical or other information necessary to process health insurance claims**. I also request payment of benefits to myself or to Ankle and Foot Center when they accept assignment. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Ankle and Foot Center to release any information necessary for my course of treatment.
- **No Shows or Cancellations with less than 24-hour notice will assess a $50 fee.** This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.
- **Ankle and Foot Center does not participate in any MEDICAID Health Plans**. You are responsible to know if you have a Medicaid Health Plan and we are unable to make this determination for you.
- I understand and agree to the above.

_____

Signed (patient or parent if minor) Date:

NAME: **DOB:**

HOW DID YOU HEAR ABOUT US? **REFERRING PHYSICIAN:**

CHIEF COMPLAINT / REASON FOR VISIT:

MEDICAL HISTORY (INCLUDE YEAR IT BEGAN):

SURGICAN HISTORY (INCLUDE YEAR OF SURGERY / PROCEDURE):

ALLERGIES: **ALLERGIES TO MEDICATIONS:**

SPORTS / HOBBIES:

MOTHER: LIVING ◯ **DECEASED** ◯ **CAUSE OF DEATH:**

FATHER: LIVING ◯ **DECEASED** ◯ **CAUSE OF DEATH:**

DO YOU SMOKE? YES ◯ **NO** ◯ **AMOUNT PER DAY?** **IF PAST SMOKER, STOP DATE?**

DO YOU DRINK? YES ◯ **NO** ◯ **OCCASIONALLY** ◯ **DAILY** ◯

MEDICATION:	CONDITION TAKING FOR:	DOSAGE:	HOW OFTEN:

PHARMACY NAME / ADDRESS / PHONE NUMBER:

I give Dr. Roman CONSENT to electronically transmit any medication prescribed to me to my named pharmacy. I agree to allow Dr. Roman to request from my pharmacy an electronic copy of my medication profile.

SIGNED:_____**DATE:**_____

NAME: **DOB:**

Are you in good health? YES ◯ NO ◯	Are you under the care of a physician? YES ◯ NO ◯	Any change in your health within the past year? YES ◯ NO ◯
When was your last physical examination?	Have you been hospitalized or had a serious illness within the past 5 years? YES ◯ NO ◯	If yes, what was the illness or operation?

Do you have or have you had any of the following diseases/problems? CHECK ✓ ONLY BOXES THAT APPLY.

☐	Rheumatic fever or rheumatic heart disease	☐	Congenital heart lesions	☐	Pain in the chest upon exertion
☐	Cardiovascular disease, which **may include any of the following**: heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke.				
☐	Shortness of breath after mild exercise	☐	Shortness of breath when you lie down, or do you require extra pillows when sleeping?	☐	Swollen ankles
☐	Asthma	☐	Hay fever	☐	Hives, skin rash
☐	Allergic or adverse reaction to Local Anesthetics	☐	Allergic to Penicillin		Allergic to other antibiotics? If yes, which?
☐	Allergic to Iodine	☐	Allergic to tape		Other:
☐	Fainting spells or seizures	☐	Diabetes	☐	Need to urinate more than 6 times a day
☐	Are you thirsty much of the time?	☐	Frequent dry mouth	☐	Hepatitis, jaundice, or liver disease
☐	Arthritis	☐	Inflammatory rheumatism (painful swollen joints)	☐	Stomach ulcers
☐	Kidney trouble	☐	Tuberculosis	☐	Have a persistent cough or cough up blood
☐	Low blood pressure	☐	Abnormal bleeding associated with previous surgery or trauma	☐	Do you bruise easily?
Have you ever required a blood transfusion? YES ◯ NO ◯		If yes, explain the circumstance:			
☐	Surgery or x-ray treatment for a tumor growth or other conditions of feet or ankles	☐	Are you taking any Antibiotics or Sulfa drugs?		If Yes, which drug?

Are you taking any of the following? CHECK ONLY BOXES THAT APPLY.

☐	Anticoagulants (blood thinners)	☐	High blood pressure medicine	☐	Cortisone
☐	Tranquilizers	☐	Aspirin	☐	Insulin, Tolbutamide, Orinase, or Similar drug?
☐	Digitalis or drugs for hearing trouble	☐	Nitroglycerin	☐	Sulfa drugs
☐	Barbiturates	☐	Sedatives, or sleeping pills	☐	Are you pregnant?

Any serious trouble associated with any previous foot or ankle treatment? If yes, explain:

Venereal Disease ◯ Syphilis ◯ Gonorrhea ◯ AIDS ◯ Other ◯

Do you have any disease, condition, or problem not listed above?

HIPAA Disclosure

Ankle and Foot Center
977 Broad Street
Bloomfield, NJ 07003
Phone: (973) 338-1111

Authorization for Use or Disclosure of Protected Health Information

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

1. Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessments and physician certifications

I give my permission for this office (Ankle and Foot Center) to leave messages on my home and/or cell phone voicemail.

_____ _____ _____

Print Patient's Name **Patient's Signature** **Date**

I make the following special request of confidential communications: The people whom, in addition to myself, may be given this confidential information are:

Name **Relationship to Patient** **Telephone**

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I acknowledge that I have received and or been granted access to your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____ _____

Print Patient's Name **Patient's Signature** **Date**