

# BRIDGEWATER FOOT CARE, LLC

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

## 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 # \_\_\_\_\_

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## **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

## **FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF:  DIABETES: TYPE 1 OR TYPE 2  CANCER  HEART DISEASE

HIGH BLOOD PRESSURE  STROKE  CORONARY ARTERY DISEASE  BLEEDING DISORDER

RHEUMATOID ARTHRITIS  OTHER \_\_\_\_\_

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**YOUR MEDICAL HISTORY**

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

REACTION: \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

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

**CURRENT PROBLEM**

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN OR SYMPTOM?

NO PAIN  SHARP  DULL  ACHING  BURNING  
 RADIATING  ITCHING  STABBING  OTHER \_\_\_\_\_

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:  STAYED THE SAME  BECOME WORSE  IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?  WALKING  STANDING  DAILY ACTIVITIES

RESTING  DRESS SHOES  HIGH HEELS  FLAT SHOES  ANY CLOSED TOE SHOE  
 RUNNING  OTHER \_\_\_\_\_

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

WAS THIS PROBLEM CAUSED BY AN INJURY?  YES  NO (DESCRIBE) \_\_\_\_\_

IF YES, WAS IT A WORK-RELATED INJURY?  YES  NO

# BRIDGEWATER FOOT CARE, LLC

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 **BRIDGEWATER FOOT CARE LLC**, 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 **BRIDGEWATER FOOT CARE LLC** 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 **BRIDGEWATER FOOT CARE LLC**, 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 **BRIDGEWATER FOOT CARE LLC**, 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

# BRIDGEWATER FOOT CARE, LLC

A DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

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: **CASH, CHECKS, OR CREDIT CARDS** 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 **BRIDGEWATER FOOT CARE LLC** for medical services provided. I agree to pay **BRIDGEWATER FOOT CARE 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 **BRIDGEWATER FOOT CARE 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: \_\_\_\_\_

