Foot & Ankle Center
of New Jersey

Skybridge Healthcare

Akamai • Wexler Foot Care

We are glad to have you as a patient. Please answer the following questions in their entirety to help us become better acquainted. If you need help, please do not hesitate to ask us for assistance.

Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: ___

Date of Birth: ____/____/____ SSN: ____-____-____

Sex: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address:

Street: _____ City/State: _____ Zip: _____

Contact Information:

Cell: (___) ____ - _____ Can we text you? ☐ Yes ☐ No Home: (___) ____ - _____

Email: _____ Best Contacted By: _____

Are you currently employed? ☐ Yes ☐ No Can we contact you at work? ☐ Yes ☐ No

Name of Employer: _____

Address of Employer: _____

Work Phone: (___) ____ - _____ Occupation: _____

Emergency Contact Information: Name: _____

Cell: (___) ____ - _____ Can we text them? ☐ Yes ☐ No Home: (___) ____ - _____

Relationship to you: _____

Pharmacy Name: _____ Phone: (___) ____ - _____

Address: _____

_____

Primary Care Physician Information:

Name: _____

Address: _____

Phone: (___) ____ - _____ Fax: (___) ____ - _____

Whom may we thank for referring you? _____

Please list any medication that you are currently taking.

Medication Name Example: Motrin	**Medication Dosage** 200 mg	**How Do You Take it? (by mouth, injection, cream, etc.)** By mouth	**When/How Often Do You Take it?** In the morning

X_____ _____

Signature of patient or patient's guardian Date

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Date: _____

Last Name: _____ First Name: _____

Personal Medical History

Height: _____ Weight: _____ Shoe Size: _____

Reason for today's visit? _____

_____

Allergies to medication? ☐ Yes ☐ No

If yes, please list the name of the medication and the type of reaction below (rash, hives, swelling, anaphylaxis, etc.).

Name of Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies: _____

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING:

Bleeding/Clotting Problems	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Last A1C (Date & Value)	_____	Liver Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Joint Pain	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	If yes, what type? When?	_____
Transplant (any)	☐ Yes ☐ No	If yes, what type? When?	_____
Cancer (any, including skin-malignant melanoma)	☐ Yes ☐ No	If yes, what type? When?	_____

If yes, did you or are you currently having chemotherapy treatments? Radiation? _____

_____

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Date: _____

Last Name: _____ First Name: _____

Continued

Any hospital admissions? ☐ Yes ☐ No

If yes, when and why? _____

Past surgeries? ☐ Yes ☐ No

If yes, when and why? _____

Any other medical conditions not listed above? (please list) _____

Are you pregnant? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

If yes, what type? ☐ Smokeless (Chew) ☐ Cigarettes ☐ Cigar/Pipe ☐ Other _____

How much? For how long? (ex: 1 tin/week 10 years, ½ pack/day 4 years, etc.) _____

Do you vape? ☐ Yes ☐ No

If yes, how much? (ex: 1 vape/week, etc.) _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type? How often? (ex: 2 cans beer/day 8 years, 3 glasses/week 6 months, etc.) _____

Do you currently use any recreational drugs? ☐ Yes ☐ No

If yes, what type? How often? _____

Have you used recreational drugs in the past? ☐ Yes ☐ No

If yes, what type? How often? When was the last use? _____

Any current illness or additional information you would like the doctor to know? _____

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Date: _____

Last Name: _____ First Name: _____

Family History:

Bleeding/Clotting Problems	☐ Yes	☐ No	Relationship: _____
Cancer (any-including malignant melanoma-skin)	☐ Yes	☐ No	Relationship: _____
			Type: _____
Diabetes	☐ Yes	☐ No	Relationship: _____
Heart Disease	☐ Yes	☐ No	Relationship: _____
Hepatitis	☐ Yes	☐ No	Relationship: _____
			Type: _____
Kidney Disease	☐ Yes	☐ No	Relationship: _____
Liver Disease	☐ Yes	☐ No	Relationship: _____
Lung Disease	☐ Yes	☐ No	Relationship: _____
Stomach Problems	☐ Yes	☐ No	Relationship: _____
Transplant (any)	☐ Yes	☐ No	Relationship: _____
			Type: _____

Additional family history you would like the doctor to know? _____

_____

_____

PODIATRIC HISTORY:

Have you been to a podiatrist previously? ☐ Yes ☐ No When? _____

Name of previous Podiatrist: _____

Address: _____

_____

Phone: (___) ____ - _____

Diagnosis & previous treatments: _____

_____

_____

Were the treatments effective? ☐ Yes ☐ No

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HEALTH INSURANCE INFORMATION

Patient Name: _____

Do you have Health Insurance? ☐ **Yes** ☐ **No**

Primary: _____

Secondary: _____

Policy Holder's Information:

Name: _____ **Date of Birth:** ____/____/_____

If the patient is under 18, who is responsible for their medical bills?

Name: _____ **Date of Birth:** ____/____/_____

Address: _____

_____

Cell Phone: (___) ____ - _____ **Home Phone:** (___) ____ - _____

PLEASE READ, SIGN AND DATE THE FOLLOWING INFORMATION

I hereby consent to be treated by the physicians of the Foot and Ankle Center of New Jersey either in person or through Telemedicine.

I understand that if I do not have insurance coverage, I will be responsible to pay Foot and Ankle Center of NJ on the day of service.

I understand that if my insurance carrier does not pay any amount due for services rendered that I will be responsible for full payment upon request. Such services include but are not limited to: any amount that has been applied to my deductible; any service not approved on my referral (if such form is required by my plan); any service considered to be cosmetic in nature and/or not covered by my insurance plan; any copay or coinsurance designated by my insurance plan.

I am aware that I have a deductible. _____ (please initial)

I understand that if I fail to obtain a referral from my primary care physician when such form is required by my plan, then I will be responsible for payment.

I hereby agree to pay Foot and Ankle Center of NJ for any non-covered services rendered.

I hereby authorize the release of information necessary to file a claim with my insurer, and/or which is pertinent to my case to any insurance company involved with my case, or to my primary care physician if requested. In addition, I authorize payment from Medicare or any other insurance company to be made on my behalf to the above facility.

A copy of this signature is as valid as the original.

X _____ Date: ____/____/_____

Signature of patient or patient's guardian

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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. I also understand that I may be subject to a $50 fee if I fail to show up to my scheduled appointment without prior notification to the office.

_____
Patient Name *(please print)*

_____
Parent/Guardian/Authorized Representative Name *(please print)* (if applicable)

X _____ _____
Signature Date