Garden State Foot Care
Dr. Larry Lodge - Podiatrist
200 B Route 73
Suite 3
Voorhees, NJ 08043
(856) 753-1300

PATIENT DEMOGRAPHICS

First Name _____ **M.I.** _____ **Last Name** _____
Social Security _____-____-_____ **Sex** ☐**F** ☐**M** **Birth Date** ____/____/____ **Marital Status** _____
E-Mail Address _____
Street Address _____
City _____ **State** _____ **Zip code** _____
Home Phone (_____) _____ **Work Phone** (_____) _____ **Cell Phone** (_____) _____

Race:
- □ American Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or other Pacific Islander
- □ White
- □ Not Specified

Ethnicity:
- □ Hispanic
- □ Not Hispanic
- □ Not Specified

Employed: FT/PT/None - Employer _____ **Primary Language** _____
Primary Care Physician _____ **Pharmacy of Choice** _____
Are you diabetic? Yes No **If yes, name of physician managing diabetes** _____
How did you hear about our practice? ☐Health Fair ☐Doctor Referral ☐Internet ☐Ad (Source _____)
☐Friend/Family Member/Patient (Name: _____) ☐ Other: _____
Emergency Contact _____ **Relationship to Patient** _____
Cell Phone Number (_____) _____ **Alternate Phone Number** (_____) _____
Financially Responsible Person First Name_____ **Last Name** _____
Social Security _____-____-_____ **Sex** ☐**F** ☐**M** **Birth Date**_____/_____/_____
Street Address _____
City _____ **State** _____ **Zip code** _____
Home Phone (_____) _____ **Work Phone** (_____) _____ **Cell Phone** (_____) _____

Insurance Information

A. Insurance Company: _____
Insurance ID Number: _____
Subscriber Name: _____
Subscriber Birth Date: _____
Relationship to Patient: _____

B. Insurance Company: _____
Insurance ID Number: _____
Subscriber Name: _____
Subscriber Birth Date: _____
Relationship to Patient: _____

Patient's Authorization and Assignment of Benefits:

I hereby authorize the processing of the medical insurance either by electronic or manual method by Garden State Foot Care. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to Garden State Foot Care. I certify that the information, I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Signature of Responsible Party _____ **Date** _____

Relationship if not patient: _____

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MEDICAL FORM

Patient Name _____ **Birth Date** _____
Last First MI

Age _____ **Height** _____ **Weight** _____ **Shoe Size** _____

Reason for your visit: _____

How long has this been a problem? _____ **When does it occur?** Morning Afternoon Evening Off and On All Day

Please list previous treatments (either prescribed or home remedies): _____

_____

List current sports/activities: _____

_____

Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	** If yes, list REACTION		Y	N	** If yes, list REACTION
Adhesive tape	__	__	_____	Foods	__	__	_____
Anesthesia	__	__	_____	Iodine	__	__	_____
Aspirin	__	__	_____	Latex	__	__	_____
Caffeine	__	__	_____	Local Anesthetics	__	__	_____
Codeine	__	__	_____	Penicillin	__	__	_____
Cortisone	__	__	_____	Sulfa Drugs	__	__	_____
Demerol	__	__	_____	Other, please list:	_____		

Please list (or attach a list) of your current medications and their dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medical History: please circle **P (personal history)** and/or **F (family history).**

P F Alcohol/Drug addiction/dependency
P F Alzheimer's/Dementia
P F Anemia – type_____
P F Arrhythmias – type _____
P F Arthritis - type_____
P F Asthma **circle** (adult or childhood)
P F Bleeding/Clotting Problems –type_____
P F Cancer - type_____
P F Depression /Anxiety disorder/Bipolar depression/other _____
P F Diabetes (how long? _____)
P F Emphysema / COPD
P F Glaucoma
P F Gout
P F GERD (Reflux) / GI ulcers (circle)
P F Headaches / Migraines
P F Hearing Problems
P F Heart Disease
P F Hepatitis A B C /Liver Disease _____
P F High Blood Pressure
P F High Cholesterol
P F HIV/ Aids/ ARC
P F Kidney/ Renal Disease
P F Lung Disease/Pulmonary Embolus
P F Lyme's Disease
P F Nervous Condition (type?)_____
P F Osteoporosis / Osteopenia (circle)
P F Phlebitis (blood clots in legs)
P F Poor Circulation / PVD
P F Rheumatic Fever / Scarlet Fever
P F Schizophrenia
P F Seizures / Epilepsy
P F STD's•(sexually•transmitted•ds.)
P F Sickle Cell Trait/Disease
P F Stroke•/•TIA's
P F Thyroid Problems (Hyper__ Hypo__)
P F Tuberculosis
P F Other, Please Specify _____
P F Other, Please Specify _____
P F **NONE of the above**

Have you been hospitalized? Y N Please list _____

Have you ever had surgery? Y N Please list _____

Social History: PLEASE FILL OUT COMPLETELY

SMOKING:
Do you or have you ever smoked? YES NO
If yes, how many years? _____ How long ago did you quit? _____

ALCOHOL USE:
Do you or did you ever drink alcoholic beverages? YES NO
How many drinks will you consume in a day? _____ Week? _____
How long ago did you quit? _____

RECREATIONAL DRUG USE:
Do you or have you ever used illicit/recreational drugs? YES NO
If yes, which ones? _____
How long ago did you quit? _____

Women: Are you currently pregnant? YES NO Due date? _____

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Garden State Foot Care to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to Garden State Foot Care to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

_____ _____
Patient or Guardian Signature Date

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Review of Symptoms

Patient Name: _____

Please check any of the following that you are currently experiencing or have recently experienced.

Constitutional:	Y	N
Do you feel fatigued during the day?		
Do you have headaches?		
Do you have a fever?		
Do you have chills?		
Do you have sweats?		
Do you have malaise?		
Have you experienced any weight loss?		
Do you feel any dizziness/fainting spells?		
Eyes:	**Y**	**N**
Do you wear glasses?		
Do you wear contacts?		
Do you have blurry vision?		
Do you have burning eyes?		
Do you have itchy eyes?		
Do you have sensitivity to light?		
Are your eyes frequently red?		
Do you have eye pain?		
Ears, Nose, & Throat:	**Y**	**N**
Do you have ringing in your ears?		
Do you get nosebleeds?		
Do you have difficulty swallowing?		
Cardiovascular:	**Y**	**N**
Have you noticed your legs or ankles swelling?		
Do you have cramping in your legs at night or at rest?		
Do you have cramping in your legs/calf when walking?		
Respiratory:	**Y**	**N**
Do you have chest pain?		
Do you have difficulty breathing?		
Do you have shortness of breath?		
Have you had a cough lasting longer than 3 weeks?		
Gastrointestinal:	**Y**	**N**
Do you have a loss in appetite?		
Do you have increase in appetite?		
Does Aspirin cause stomach pain?		
Do you have a history of stomach ulcers?		
Do you have heartburn?		
Do you have bloody or dark stools?		
Genitourinary:	**Y**	**N**
Do you have pain with urination (dysuria)?		
Have you noticed blood in your urine (hematuria)?		
Do you have any discharge?		
Do you urinate more frequently than before?		
Do you have burning with urination?		
Hematologic/Lymphatic:	**Y**	**N**
Do you bruise easily?		
Do you have any abnormal bruising?		
Are you bleeding?		
Allergic/Immunologic:	**Y**	**N**
If you get cut, does it take a long time to heal?		
Do you have allergic reactions to medication(s)?		
Do you have allergic reactions to foods?		
Do you have allergic reactions to dye?		

Musculoskeletal:	Y	N
Do you have low back pain?		
Do you have pain in your leg?		
Do you have foot pain?		
Do you have joint pain?		
Do you have bone pain?		
Do you have general muscle aches or pains?		
Have you had swelling in your legs?		
Have you had joint swelling or stiffness?		
Have you noticed a change in the way you walk?		
Is it difficult to climb stairs?		
Are you experiencing a loss of strength in your leg?		
Do you limp when you walk?		
Do your shoes wear out quickly or unevenly?		
Integumentary (Skin):	**Y**	**N**
Is your skin strongly sensitive when exposed to the sun?		
Do you have any skin rashes?		
Do you have any warts on your feet?		
Do you have any moles, lumps, or bumps on your skin?		
Do you have extremely dry skin or cracking?		
Do you have open skin sores?		
Are there unusual areas of discoloration on your skin?		
Do you have any corns or calluses on your feet?		
Are your nails unusually thick?		
Are your nails deformed?		
Are your nails ingrown and tender?		
Do your nails cause you pain?		
Do you have noticeable hair loss on your legs or feet?		
Neurological:	**Y**	**N**
Do you ever feel dizzy?		
Do you often feel confused or disoriented?		
Do you have problems with your balance?		
Do you have frequent or reoccurring headaches?		
Do you have seizures?		
Do you have tremors of your extremities?		
Do your legs often feel like they are going to sleep?		
Do you have numbness in your legs?		
Do you have a feeling of burning in your legs?		
Do you have pain in the legs with walking or exercises?		
Do you have leg pain that is worse at night or rest?		
Do you have leg pain all the times?		
Do you experience shooting pains down your legs?		
Do you have paralysis (complete loss of muscle strength in legs)?		
Psychiatric:	**Y**	**N**
Do you have a history of psychiatric problems?		
Are you subject to mood swings?		
Are you under a lot of stress?		
Endocrine:	**Y**	**N**
Are you excessively thirsty?		
Do you have a history of bad breath?		
Are you experiencing night sweats?		
Do you have swollen glands?		
Have you had a significant weight change recently?		

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FINANCIAL POLICY

Welcome to Garden State Foot Care and thank you for selecting our practice. We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

1. Your insurance is a contract between you, your employer, and the insurance company. It is your responsibility to understand the benefits of your plan. We cannot guarantee payment of your claims because your insurance company will not give us such guarantee. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Balances older than 30 days are subject to $5.00 per month fee. Returned checks are subject to a $35.00 fee. These fees are intended to cover costs incurred by our office.

2. We participate in a number of health insurance plans. All patients are required to pay their co-pay at time of check in. Patients that do not pay their co-pay at time of visit will be charged an additional $5.00. In addition, HMO patients must present a valid referral/authorization from their primary physicians at check in. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you wll be responsible for the entire charge. We will attempt to verify benefits for some specialized services; however you remain responsible for charges to any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits prior to services rendered.

3. MEDICARE PATIENTS – Please understand that we participate with Medicare. However, you are responsible for your co-insurance, deductible, and any non-covered services. If Medicare has provided reimbursement for services rendered, and if your supplemental insurance does not respond within 30 days, then you become responsible for the balance.

4. Filings of insurance claims are a courtesy that we extend to our patients and all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We accept cash, check and all major credit cards for payment.

5. Missed appointments: You will be billed a $40.00 charge for missed appointments not cancelled with at least 24 hours notice.

6. If you believe your insurance company has erred or not adequately addressed your claims, you may contact the insurance company and/or file a grievance or appeal with the Insurance Administration in your state.

I, _____, have read and I understand the above financial policies. These policies
(Name of patient)
are subject to change without prior written confirmation.

_____ _____
Signature of patient or legal representative Date

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SUMMARY NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please contact:
Teri Lodge, Administrator at 856-753-1300 or gardenstatefootcare1@gmail.com

I, _____, acknowledge that I was provided a copy of the Notice of Privacy Practices
(Name of patient)
and that I have read or had the opportunity to read if I so chose and understood the Notice. By signing below, I hereby authorize Garden State Foot Care to obtain Medication History related to the patient above.

In addition, I authorize the following, _____ access to my personal health information upon request.

_____ _____
Signature of patient or legal representative Date