RIDGEWOOD & CLIFTON FOOT & ANKLE CENTERS
PLEASE PRINT THE FOLLOWING INFORMATION CLEARLY:

PATIENT NAME _____ MALE FEMALE MARITAL STATUS _____

PARENT (GUARDIAN'S NAME IF APPLICABLE) _____ SS # _____

PATIENT'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # ( ) _____ WORK # ( ) _____ CELL # ( ) _____

PATIENT'S AGE _____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____

EMERGENCY CONTACT NAME _____ PHONE # ( ) _____

WHO REFERRED YOU TO OUR OFFICE? _____FRIEND/RELATIVE ____ PHYSICIAN ____ INSURANCE _____ OTHER

HAVE YOU EVER BEEN TO A PODIATRIST (FOOT DOCTOR) BEFORE? YES NO LAST VISIT? _____

WHAT IS YOUR FOOT PROBLEM? PLEASE INDICATE WHICH FOOT, TOE, ANKLE, ETC: _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ IS THIS ACCIDENT RELATED? YES_____ NO _____

WHERE DID THIS ACCIDENT HAPPEN? WORK _____ HOME _____ CAR _____ OTHER _____

MEDICAL DOCTOR'S NAME _____PHONE # ( ) _____ ADDRESS _____

WHEN WAS YOUR LAST VISIT WITH HIM/HER? _____ REASON? _____

PHARMACY NAME _____ PHONE # ( ) _____

***GENERAL HEALTH*: CHECK ANY OF THE FOLLOWING CONDITION THAT YOU HAVE:**

_____ **DIABETES**	_____ PERIPHERAL VASCUALR DISEASE/**POOR CIRCULATION**	_____ GOUT
_____ HEART DISEASE	_____ HYPERTENSION / HIGH BLOOD PRESSURE	_____ EMPHYSEMA
_____ RENAL DISEASE	_____ CEREBRAL ACCIDENTS / STROKE	_____ ASTHMA
_____ **HIV +**	_____ HEMOPHILLIAC / BLEEDER	_____ GLAUCOMA
_____ **HEPATITIS A,B,C,**	_____ SCARLET / RHEUMATIC FEVER	_____ ARTHRITIS
_____ TUBERCULOSIS	_____ OTHER _____	

ARE YOU PRESENTLY TAKING ANY MEDICATION? (INCLUDING BIRTH CONTROL) YES NO PLEASE LIST:

_____

ALLERGIES: IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING, PLEASE CHECK:
____PENICILLIN ____NOVOCAINE ____ ADHESIVE TAPE ____ CORTISONE ____CODIENE ____ IODINE ____ LATEX
____OTHER, PLEASE LIST _____

PAST MEDICAL HISTORY: PLEASE ANSWER *YES* OR *NO* TO THE FOLLOWING, IF YES, PLEASE EXPLAIN
HAVE YOU HAD ANY SERIOUIS ILLNESSES OR OPERATIONS? _____
HAVE YOU HAD ANY INJURY REQUIRING MEDICAL ATTENTION? _____
HAVE YOU HAD ANY FOOT SURGERY? _____ WHEN? _____ REASON? _____

FAMILY MEDICAL HISTORY: HAS ANY MEMBER OF YOUR FAMILY HAD/HAVE ANY OF THE FOLLOWING?

_____ **DIABETES**	_____ PERIPHERAL VASCUALR DISEASE / BLOOD VESSELS	_____ GOUT
_____ HEART DISEASE	_____ HYPERTENSION / HIGH BLOOD PRESSURE	_____ ASTHMA
_____ ARTHRITIS	_____ OTHER _____	

IF YOUR PARENT(S) IS/ARE DECEASED, WHAT WAS THE CAUSE OF DEATH? _____
DID YOU OR DO YOU SMOKE _____ IF YES, HOW LONG? _____ HOW MANY PER DAY? _____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT

_____

(PATIENT SIGNAGTURE, OR IF A MINOR, PARENT'S OR GUARDIAN'S SIGNATURE)

THIS SECTION IS FOR THE INSURANCE DEPARTMENT AND IT IS NECESSARY THAT YOU COMPLETE THIS FORM AS FULLY AND ACCURATELY AS YOU CAN. WE NEED THIS INFORMATION SO WE CAN PROCESS ALL INSURANCE CLAIMS AS QUICKLY AND EFFICIENTLY AS POSSIBLE. **THANK YOU.**

PLEASE BE AWARE: DIVORCED PARENTS: THIS OFFICE POLICY REQUIRES THE PARENT ACCOMPANYING THE CHILD FOR THE TREATMENT WILL BE HELD RESPONSIBLE FOR ALL BILLS. WE CANNOT BILL THE OTHER PARENT.

PRIMARY INSURANCE COMPANY INFORMATION:

PRIMARY INSURANCE CARRIER _____ ID # _____

INSURANCE ADDRESS _____ PHONE # ( ) _____

INSURED'S (GUARDIAN) NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE_____ ZIP _____

HOME PHONE # ( ) _____ SS # _____ INSURED'S DATE OF BIRTH _____

INSURED'S EMPLOYER _____ BUSINESS PHONE # ( ) _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE COMPANY INFORMATION:

SECONDARY INSURANCE CARRIER _____ ID # _____

INSURANCE ADDRESS _____ PHONE # ( ) _____

SIGNATURE ON FILE: IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US OR FOR REIMBURSEMENT TO YOU FOR SERVICES COVERED UNDER YOU POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER.

I HEREBY AUTHORIZE DR. JEFFREY CONFORTI, HIS OFFICE OR HIS DESIGNATED ASSOCIATE, TO SUBMIT A CLAIM TO THE INSURANCE CARRIER I LISTED ABOVE OR IT'S INTERMEDIARIES, FOR ALL COVERED SERVICES. I DIRECT MY INSURANCE CARRIER OR IT'S INTERMEDIARIES, TO ISSUE PAYMENT CHECK(S) DIRECTLY TO DR. JEFFREY CONFORTI, HIS OFFICE OR HIS DESIGNATED ASSOCIATE, FOR SERVICES I DID NOT PAY FOR.

I UNDERSTAND THAT MEDICARE AND PRIVATE INSURANCE CARRIERS DO NOT COVER ALL MEDICAL SERVICES AND THAT I AM FINANCIALLY RESPONSIBLE TO DR. JEFFREY CONFORTI, HIS OFFICE OR HIS DESIGNATED ASSOCIATE FOR ANY BALANCE(S) OR SERVICE(S) NOT COVERED BY MY INSURANCE CARRIER OR COVERED SERVICES THAT ARE NOT PAID FOR BY MY INSURANCE COMPANY WITHIN 30 DAYS OF MY VIIST TO THE OFFICE.

I GIVE PERMISSION TO DR. JEFFREY CONFORTI, HIS OFICE OR HIS DESIGNATED ASSOCIATE, TO ADMINISTER APPROPRIATE CARE NECESSARY IN THE DIAGNOSIS AND TREATMENT FOR CONDITIONS, IF ANY, FOR MYSELF AND ANY PERSON(S) I AM LEGALLY RESPONSIBLE FOR.

I UNDERSTAND THAT DR. JEFFREY CONFORTI IS PART OWNER IN THE CENTER FOR SPECIAL SURGERY LOCATED IN HAWTHORNE, NJ AND THAT I HAVE A CHOICE IN GOING TO A DIFFERENT FACILITY IF I REQUIRE SURGERY. I ALSO HAVE READ AND UNDERSTAND THE HIPPA PRIVACY STATEMENT THE OFFICE MADE AVAILABLE TO ME. I AUTHORIZE AND ALLOW DR. CONFORTI'S OFFICE TO FORWARD ANY AND ALL INFORMATION CONCERNING MY CARE TO ANY ENTITY, PERSON OR AUTHORITY THAT CAN OR WILL ASSIST THE OFFICE TO COLLECT ANY FEE DUE THE OFFICE THAT RESULTS FROM THE CARE RECEIVED.

I UNDERSTAND THAT DUE TO INSURANCE COMPANY *TIMELY FILING REQUIREMENTS*, IT IS THE PATIENT'S / GUARDIAN'S RESPONSIBILITY TO ENSURE THAT THIS OFFICE HAS UP TO DATE INSURANCE INFORMATION BEFORE EACH VISIT. IF THE OFFICE IS NOT GIVEN PROPER INSURANCE INFORMATION AT THE TIME OF SERVICE, THE BILL WILL BE THE PARENT'S / GUARDIAN'S RESPONSIBILITY.
A COPY OF THIS SIGNATURE IS A VALID AS THE ORIGINAL.

_____ DATE _____

(PATIENT'S SIGNATURE, OR IF A MINOR, PARENT(S) OR GUARDIAN(S) SIGNATURE)