PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of South Jersey Foot and Ankle Institute. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

First Name: _____ **Last Name**: _____

Date of Birth: _____ **Gender**: □ Male □ Female □ Other

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Home Phone: _____ **Mobile Phone**: _____

SSN (Optional) : _____ **E-Mail**: _____

Ethnicity/Race: _____ **Weight**: _____ **Height**: _____

Primary Language: □ English □ Spanish □ Other: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse Name: _____ **Spouse Phone**: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ **E-Mail**: _____

Home Phone: _____ **Mobile Phone**: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ **ID #**: _____

Primary Insurance Type: □ HMO □ PPO □ Medicare □ Other: _____

Complete the following if you are ***not*** the policyholder for your primary insurance:

Insurance Policyholder: □ Spouse □ Child □ Parent □ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

Policyholder Social Security Number (Optional): _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ **ID #**: _____

Primary Insurance Type: □ HMO □ PPO □ Medicare □ Other: _____

Complete the following if you are ***not*** the policyholder for your secondary insurance:

Insurance Policyholder: □ Spouse □ Child □ Parent □ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

Policyholder Social Security Number: _____

TREATING PHYSICIANS

Primary Care Physician: _____ **Date Last Seen**:_____

Phone: _____

Referring Physician: _____**Date Last Seen**:_____

Phone: _____

List all other active treating physicians:

Physician Name: _____ **Specialty**: _____
Physician Name: _____ **Specialty**: _____
Physician Name: _____ **Specialty**: _____
Physician Name: _____ **Specialty**: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____

Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____

FAMILY HEALTH HISTORY

List any major conditions/illnesses that your immediate family members have had:

Relative	Condition	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	
Other:		□ Y □ N	

SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

Description	Doctor	Location	Year

MEDICAL HISTORY

Have you ever had any of the following?

Anemia	□ Y □ N	Hypertension	□ Y □ N
Arthritis Conditions	□ Y □ N	Hepatitis	□ Y □ N

Asthma	□ Y □ N	Hypothyroidism	□ Y □ N
Atrial Fibrillation	□ Y □ N	Infection Problems	□ Y □ N
Bleeding Problems	□ Y □ N	Insomnia	□ Y □ N
Blood Clot	□ Y □ N	Irritable Bowel Syndrome	□ Y □ N
Coronary Artery Disease	□ Y □ N	Kidney Problems	□ Y □ N
Cancer	□ Y □ N	Menopause	□ Y □ N
Cardiac Arrest	□ Y □ N	Migraines/Headaches	□ Y □ N
Circulatory problems	□ Y □ N	Neuropathy	□ Y □ N
Chest Pain	□ Y □ N	Onychomycosis	□ Y □ N
Congestive Heart Failure	□ Y □ N	Organ Injury	□ Y □ N
COPD	□ Y □ N	Osteoporosis	□ Y □ N
Depression	□ Y □ N	Pulmonary Embolism	□ Y □ N
Diabetes	□ Y □ N	Rheumatoid Arthritis	□ Y □ N
Drug/Alcohol Abuse	□ Y □ N	Shortness of Breath	□ Y □ N
Emphysema	□ Y □ N	Stroke	□ Y □ N
Fibromyalgia	□ Y □ N	Seizure Disorders	□ Y □ N
Gout	□ Y □ N	Skin disorders	□ Y □ N
Heart Disease	□ Y □ N	Tremors	□ Y □ N
Hyperinsulinemia	□ Y □ N	Venous Insufficiency	
Hyperlipidemia	□ Y □ N		

List any other medical problems that you have had:

HEALTH CONCERNS

What's your primary health concern? _____

Approximately when did this issue begin? _____

Does the issue cause you pain? □ Yes □ No

- If so, where? _____

How has the pain changed since it began? □ Increased □ Decreased □ Unchanged
How quickly did your current pain begin? □ Gradually □ Suddenly

How often does your pain occur? □ Constantly □ Occasionally □ Rarely

When is your pain at its worst? □ Morning □ Afternoon □ Evening □ Night

What are your current symptoms? _____

Check any of the following that describe your pain:

Aching	☐	Numbness	☐	Spasming	☐	Throbbing	☐
Cramping	☐	Shock-like	☐	Squeezing	☐	Tingling	☐
Dull	☐	Shooting	☐	Stabbing/Sharp	☐	Tiring/Exhausting	☐
Hot/Burning	☐						

List any other health concerns that you would like us to know about:

SOCIAL HISTORY

Do you currently consume alcohol? □ Yes □ No
- How many drinks per week? _____

Do you currently smoke? □ Yes □ No
- What do you smoke? □ Tobacco □ Marijuana □ Other: _____
- How many cigarettes do you smoke per day? _____

Do you currently use any other drugs? □ Yes □ No
- What other drugs do you take? _____
- How often? □ Daily □ Weekly □ Occasionally □ Rarely

Do you drink caffeine? □ Yes □ No
- How many cups per day? _____

How frequently do you exercise? □ Daily □ Weekly □ Occasionally □ Rarely

Are you on a special diet? □ Yes □ No
- What diet? _____

Complete the following if applicable:
Are you planning a pregnancy? □ Yes □ No
Are you pregnant now? □ Yes □ No
Are you nursing now? □ Yes □ No
What type of contraception do you currently use? _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____

Privacy Information Preferences

Can we call the phone number on file? □ Yes □ No
Can we leave a voicemail? □ Yes □ No **Can we text you?** □ Yes □ No
Can we send mail to the address on file? □ Yes □ No
Can we send internet-based (email) reminders? □ Yes □ No
Who can we leave a message with? □ Wife □ Husband □ Partner □ Son □ Daughter □ Other:
_____ Name(s):_____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up-to-date to the best of my knowledge.
b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.
g) **Please Read and Sign.** The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ **Date**: _____

Print Name: _____