Mercer-Ocean Podiatry, PC

Dr. Frank Killian, DPM, FACFAS *Dr. Sameep Chandrani, DPM, AACFAS*

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name (Last, First, MI): Date:

SSN: Date of Birth: Age: Sex (Circle One): Male Female

E-Mail Address: Marital Status (Circle One): S M W D SEP

Street Address:

City, State, Zip Code:

Home Phone Number: Alternate/Cell Phone Number:

Race (Circle One): American Indian or Alaska Native Asian Black or African American White Native Hawaiian or Pacific Islander

Hispanic Other Decline to State

Preferred Language:

Employer: Employer Phone Number: Occupation:

PRIMARY INSURANCE INFORMATION

Primary Insurance Company:

Policy Number: Group Number:

Subscriber Name: Subscriber D.O.B: Subscriber Phone Number:

Subscriber Employer: Patients Relationship to Subscriber:

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company:

Policy Number: Group Number:

Subscriber Name: Subscriber D.O.B: Subscriber Phone Number:

Subscriber Employer: Patients Relationship to Subscriber:

EMERGENCY CONTACT

Emergency Contact Name (Last, First, MI): Relation to Patient:

Emergency Contact is Parent/Guardian (Circle One): Y N Phone Number:

MEDICAL CONTACTS

Primary Care Physician: Phone Number:

Address (Including City/State/Zip Code):

Pharmacy: Address: Phone Number:

AUTHORIZATION

1. *I hereby authorize the release of medical or orhter information necessary to process health insurance claims. I also request payment of benefit to myself or my provider, Mercer – Ocean Podiatry, when assignment is accepted*
2. *I hereby authorize my provider, Mercer – Ocean Podiatry, to release any information necessary for my course of treatment to my other providers or my insurance companies, when requested, only.*

Signature: _____ Relationship to Patient: _____ Date: _____

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PATIENT MEDICAL HISTORY

PATIENT INFORMATION

Patient Name (Last, First, MI): Date:

Statistics: Height: Weight: Shoe Size:

Chief Complaint (Please describe current problem):

MEDICATIONS (PRESCRIPTION & NONPRESCRIPTION)

Medication Name	Dosage	Medication Name	Dosage

ALLERGIES

Please List:

MEDICAL HISTORY (Please CHECK all that apply)

☐ Arthritis/Bone-Joint Problems	☐ Lyme Disease
☐ Anemia	☐ Neuromuscular Disease
☐ Asthma/Lung Problems	☐ Numbness/Weakness
☐ Back Problems	☐ Pacemaker
☐ Bleeding Problems	☐ Polio
☐ Blood Clots	☐ Positive Culture for MRSA/VRE
☐ Cancer	☐ Positive Test for HIV
☐ Chemotherapy	☐ Previous or Current Diabetic Foot Wounds
☐ Chest Pain/Heart Problems	☐ Prostate Problems (Males)
☐ Circulatory Problems	☐ Recent Weight Gain/Loss
☐ Diabetes Type 1	☐ Scoliosis
☐ Diabetes Type 2	☐ Seizures/Epilepsy
☐ Dropfoot	☐ Sickle Cell Disease or Trait
☐ Eye Problems	☐ Skin Problems/Cancer
☐ Gout	☐ Sleep Apnea
☐ Gynecological Problems (Females)	☐ Stroke Date:
☐ Head and Neck Problems	☐ Stomach/Intestinal Problems/Ulcers
☐ Heart Attack Date:	☐ Tetanus Immunization Date:
☐ Hepatitis/Liver Disease	☐ Thyroid Problems
☐ High Blood Pressure	☐ Tuberculosis
☐ High Cholesterol	☐ Urinary Tract Problems
☐ Injury/Trauma Kidney Problems	
☐ Kidney Dialysis	☐ No Past Medical History
☐ Lower Extremity Wounds	

Please list any other medical conditions not mentioned above:

Details regarding ANY significant health events in the past 6 months:

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FAMILY HISTORY
Mother: Living _____ Deceased _____ Father: Living _____ Deceased _____ Siblings: Indicate # of siblings _____
Does anyone in your IMMEDIATE family have any of the previously mentioned medical problems? If yes, please describe:

SURGICAL HISTORY
Please list the surgery and date performed:
Do you have any internal metal or other implants (pins, grafts, screws, plates, clips, joints)? If yes, please describe:

SOCIAL HISTORY				
Do you smoke? (Circle One)	YES	NO	If yes, how much?	If you quit, when?
Do you drink? (Circle One)	YES	NO	If yes, how much?	If you quit, when?
Use recreational drugs? (Circle One)	YES	NO	If yes, how much?	If you quit, when?
Are you pregnant? (Circle One)	YES	NO	If no, are you trying to become pregnant? (Circle One)	YES NO
Do you participate in physical fitness activities? (Circle One)	YES	NO	If yes, how often?	

OFFICE INFORMATION

ADVERTISING
How did you learn about our practice? (Circle One)
Friend Patient Relative Doctors Office Internet Insurance Carrier Newspaper/Magazine Other:

WEBSITE
Did you find our website helpful? (Circle One) YES NO Did Not Use

Our office maintains compliance with the infection control standards mandated by the CDC and OSHA

PLEASE SIGN
To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be hazardous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff of Mercer – Ocean Podiatry, P.C. to perform the necessary services I may need.
Signature of Patient or Parent of Minor: _____ Date: ___ / ___ / _____

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REQUESET FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Mercer – Ocean Podiatry, P.C., and/or its staff be handled in the follow manner:

1. For **WRITTEN** Communication: Address to:

_____

_____

_____

2. For **ORAL** Communication: Call Telephone #: _____

3. For **E-MAIL** Communication: _____

4. I give my permission for Mercer – Ocean Podiatry, P.C. to leave a message on my voicemail.

Signature: _____

Date: ___ /___ / _____

As a patient of Mercer – Ocean Podiatry, P.C., you also have the right to not receive any communication from our office. If you would like to opt out of receiving any form of communication from our office, which includes reminder phone calls, calls from one of our doctors or staff with potential important information, etc., please sign and date below. ***(Only sign below if you have not signed above)***

Signature: _____

Date: ___ /___ / _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS

I understand that, under the Health Insurance Portability Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have asked for, received, read, and understood Mercer – Ocean Podiatry's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address and phone number below to obtain a current copy of the Notice of Private Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my request restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: ___ /___ / _____

*Do we have **permission** to verbally discuss your health information with family members or friends? If so, whom?

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

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FINANCIAL POLICIES & CONSENTS

1. **Insurance Assignment and Release Authorization**

I, the undersigned, have health insurance coverage (please enter name of your insurance) _____ and assign directly to Mercer - Ocean Podiatry, P.C. all medical benefits. I authorize the use of this signature on all my insurance submissions and authorizations. If any, otherwise payable to me for services rendered to me or my dependents. I hereby authorize the doctor and his staff to release all information necessary to secure the payment of benefits.

2. Coinsurance, Copayments, Deductibles, Noncovered Services and Supplies

Copayments, noncovered services and supplies are due at the same time of service. We accept all types of payments (cards, checks, cash). All payments are due at the time of your appointment. Balances over 30 days are subject to monthly service charge. Balances over 60 days from time of service are considered delinquent and will be turned over to an outside collections service. I understand that my insurance carrier may exclude/disallow coverage for certain services, treatment, medication, appliances, orthotics, or other durable medical equipment that the physician may prescribe or recommend, and that I will be financially responsible for these noncovered charges. Furthermore, I understand that I cannot return such items for a refund because such items are considered single patient use only.

Our office may charge a $15.00 fee for all forms completed by our staff. There will be a 5-7 day turn around time for the completion of these forms

3. Uninsured Patients

Payment in FULL is required at the time services are rendered and supplies dispensed.

4. Referral Authorization

Your insurance carrier may require authorization from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referral authorizations prior to your visit. Contact your insurance carrier if you have questions in regards to this issue.

5. Appointment Cancellations

Please give our office a 24-hour notice if your appointment needs to be cancelled or rescheduled to avoid a $25.00 no-show fee.

6. Assignment of Rights and Benefits

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case. I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

7. DMV Handicap Parking Application, Medical Records

There is a $10.00 fee for ALL DMV handicap parking application.
ATTORNEYS ONLY: For medical records, an initial $10.00 search fee is placed, with an additional $1.00 per page. (P.L. 1971, c. 136 (C.26:2H-1))

8. Surgery Cancellation Fee:

Any surgeries cancelled within 14 business days of the scheduled surgery will incur a $250.00 fee, surgeries cancelled 72 hours prior to scheduled surgery will incur a $500.00 fee. (Fee will be waved if cancellation is due to a death in the family, illness, or if the patient is not cleared for surgery)

9. Returned Checks

Any returned check from a bank for non – payment (insufficient funds) shall result in the patient's account being assessed a $40.00 fee per check.

By subscribing my name below, I acknowledge my understanding and agreement of all above terms and conditions.

Patient/Guarantor Signature: _____

Patient Name: _____

Date: ____ / ____ / _____