



(Please Print)

REGISTRATION FORM

Today's Date ____/____/____

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Sr.
				<input type="checkbox"/> Dr. <input type="checkbox"/> Miss	<input type="checkbox"/> Jr.
Street Address			City	State	Zip Code
Home Phone # () ()	Cell Phone # () ()	Work Phone # () ()	E-mail Address		
Patient's Birth Date	Age	Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Widow <input type="checkbox"/> Div		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Parent or Guardian (if patient is under 18 years of age):			Relationship to Patient:		

INSURANCE INFORMATION

Primary Insurance	Policy Holder	Relationship to Policy Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Policy Holder's Birth Date
Policy Holder's Employer	Policy Holder's Employer Address		
Secondary Insurance	Policy Holder	Relationship to Policy Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Policy Holder's Birth Date

Check Here if: **Today's visit is related to an auto accident or worker's compensation. Please ask for additional paperwork.**

Whom may we thank for referring you?

<input type="checkbox"/> Doctor -	<input type="checkbox"/> Family -
<input type="checkbox"/> Hospital -	<input type="checkbox"/> Friend -
<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Google/Internet -
<input type="checkbox"/> Caruso Website <input type="checkbox"/> Facebook	<input type="checkbox"/> Other _____

Name of contact in case of an emergency	Relationship	Phone
Name of nearest relative not living with you	Address	Phone

Do you have a Living Will? (for patients 18 yrs. & above) Yes No

FAMILY PHYSICIAN INFORMATION (Please fill in as much information as possible)

Medical Doctors Name	Date Last Seen by Family Physician:		
Street Address	City	State	Phone Number: () ()

Please list any specialist currently treating you:

Specialist:	Specialist:	Specialist:
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Reason for Today's Visit: HOW LONG?

_____ MONTHS _____ YEARS

PATIENT NAME

BIRTH DATE

/ /



SHOE SIZE	HEIGHT	WEIGHT	BLOOD SUGAR	LAST BLOOD PRESSURE
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DO YOU SMOKE NOW?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	# OF PACK(S)/DAY	DO YOU DRINK?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
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HAVE YOU SMOKED IN THE PAST	<input type="checkbox"/> NO	<input type="checkbox"/> YES	DRINKS PER WEEK
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ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

<input type="checkbox"/> No Known Allergies	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine on Skin	<input type="checkbox"/> Other _____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tape	<input type="checkbox"/> Local Anesthetic	
	<input type="checkbox"/> Latex	<input type="checkbox"/> Nausea From Anesthetic	
	<input type="checkbox"/> Codeine	<input type="checkbox"/> Anti-inflammatory Medication	

PAST SURGICAL HISTORY

Have you ever been put to sleep for surgery? Yes No

Please list any previous surgeries that you have had:

Family History - Has anyone in your FAMILY ever suffered from any of the following?

Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> None
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> None
Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> None
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> None
Thyroid Disorders	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> None
Other: _____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> None

Indicate which of the following YOU have had or have at present. Check Yes or No to each item

Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes: Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	H.I.V. Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back or Neck Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots or DVT	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breathing Problems (Asthma, Emphysema, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric/Psychological Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Problem/Reflux/Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease/Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

Indicate which of the following you have had or have at present. Check Past or Current for each item.

Foot / Leg Injuries	<input type="checkbox"/> Past	<input type="checkbox"/> Current	Weak Ankles	<input type="checkbox"/> Past	<input type="checkbox"/> Current	Foot Skin Problems	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Foot / Leg Surgery	<input type="checkbox"/> Past	<input type="checkbox"/> Current	Bunions	<input type="checkbox"/> Past	<input type="checkbox"/> Current	Unequal leg Length	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Foot / Leg Cramps	<input type="checkbox"/> Past	<input type="checkbox"/> Current	Knee Pain	<input type="checkbox"/> Past	<input type="checkbox"/> Current	Foot / Leg Numbness	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Foot Ulcers	<input type="checkbox"/> Past	<input type="checkbox"/> Current	Other Foot/Leg Problems: _____					

Have you had previous treatment by a Podiatrist? Yes No For What?

What previous treatments have you had on your foot/ankle? Surgery Orthotics Oral Medications Cortisone Shots

PATIENT NAME

BIRTH DATE / /

MEDICATIONS

PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION & OVER THE COUNTER

MEDICATION	DOSAGE
I give Caruso Foot and Ankle LLC permission to access my medications electronically. <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Check here if you are not taking any medications	

PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy: Costco CVS Rite Aid Target Wal-Mart Walgreens Wegman's Shoprite
 Medco Other: _____

Address or Cross Streets	City	State	Zip Code
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Phone Number ()	<input type="checkbox"/> This is a mail order pharmacy
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The following questions are completely voluntary. We are making a good faith effort to record this information in order to comply with legal requirements

Race/Ethnic Identification: **Check here if you wish to not participate**

<input type="checkbox"/> American Indian/Alaska Native
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
<input type="checkbox"/> African American(Non-Hispanic or Latino origin)
<input type="checkbox"/> White(Non-Hispanic or Latino origin)
<input type="checkbox"/> Asian
<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Other

Primary Language: _____

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature	Date
X	

For Office Use Only: HISTORY REVIEWED BY:	Date
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Patient Name: _____

FINANCIAL RESPONSIBILITY

It is your responsibility to provide us with your current insurance card at **every visit** so that we may bill the insurance company in a timely fashion. If a claim is rejected due to an expired policy or due to non-covered services, you will be held responsible for the outstanding balance. Due to the wide variety of insurance plans, even within one insurer, it is impossible for us to know what is covered under your plan. It is your responsibility to know your insurance plan. Any health insurance deductibles, co-payments and/or co-insurance are your responsibility. You must obtain referrals, second opinions, exclusions of 'pre-existing conditions' and/or other requirements or conditions of your insurance coverage. There is also a \$50.00 fee for checks returned for insufficient funds.

MISSED APPOINTMENTS: We understand that you may not be able to keep all of your scheduled appointments. Please understand that missed appointments have a detrimental impact on our practice, not only financially, but they also affect our ability to serve others in need of medical care.

A \$25 fee will be charged for all appointments not cancelled at least 24 hours in advance. You can be seen in the office after any no show fees have been paid.

FORMS AND MEDICAL RECORDS FEES: Due to the increasing cost of providing our patients with the highest standards of care, we must impose a charge for records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. The following charges apply:

All Forms and Dictated letters: \$5.00 each

(Other charges will apply for copies of records for personal use.)

ASSIGNMENT OF BENEFITS/PATIENT RESPONSIBILITY FORM

The signature below entitles us to release or disclose to any insurance company, governmental agency, managed care organization and any other entity or person who may be required to pay all or part of the costs of your treatment, hospitalization and/or all medical records or other information from our records relating to you identity, diagnosis, prognosis and treatment. The purpose for the disclosure is to enable Caruso Foot & Ankle LLC to secure payment of your bill from all companies/entities that may be required to pay on your behalf. Your insurance company has your permission to pay on your account directly to Caruso Foot & Ankle LLC for all professional and/or medical expenses. You agree to pay, in a timely manner, any balance of said professional service charges over and above or not covered by your insurance company. A photocopy of this *Agreement* will be considered as effective and valid as the original.

Signature: _____

Date: _____

Printed Name: _____

Relationship to Policy

Holder: _____



Patient Name: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Caruso Foot & Ankle LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Notice of Privacy Practices provided by Caruso Foot & Ankle LLC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Caruso Foot & Ankle LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Patricia O'Rourke, Office Manager at 38 Thoreau Drive Freehold, NJ 07728.

With this consent, Caruso Foot & Ankle LLC may call your home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Caruso Foot & Ankle LLC may mail or e-mail to my house or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder calls and patient statements. I have the right to request that Caruso Foot & Ankle LLC restrict how it used or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by agreement.

By signing this form, I am consenting to allow Caruso Foot & Ankle LLC to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Caruso Foot & Ankle LLC may decline to provide treatment to me.

Furthermore, I allow my PHI to be discussed with the following persons:

_____ **Primary Care Physician**

_____ **Family Members** (Please list members below)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ **Other:** _____

Signature of Patient or Legal Guardian: _____

Date: _____ Legal Guardian Name, if applicable: _____