(Please Print)

REGISTRATION FORM

Today's Date______/______/______

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs ☐ Dr. ☐ Miss	☐ Sr. ☐ 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** ☐Single ☐Mar ☐Widow ☐Div	**Sex** ☐ M ☐ 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 ☐ Self ☐ Spouse ☐ Child ☐ Other	**Policy Holder's Birth Date**
Policy Holder's Employer	Policy Holder's Employer Address		
Secondary Insurance	Policy Holder	Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ 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?

☐ Doctor -	☐ Family -
☐ Hospital -	☐ Friend -
☐ Insurance Plan	☐ Google/Internet -
☐ Caruso Website ☐ Facebook	☐ 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

Do you have an advanced directive? ☐ Yes ☐ No

Do you have a POA? If yes, what is the name? ☐ 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:

Reason for Today's Visit: ______________________________

HOW LONG? MONTHS YEARS

PATIENT NAME **BIRTH DATE** / /

SHOE SIZE	HEIGHT	WEIGHT	BLOOD SUGAR	LAST BLOOD PRESSURE

DO YOU SMOKE NOW?	☐ NO	☐ YES	# OF PACK(S)/DAY	**DO YOU DRINK?**	☐ NO ☐ YES
HAVE YOU SMOKED IN THE PAST	☐ NO	☐ YES		DRINKS PER WEEK	

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

☐ No Known Allergies
☐ Penicillin
☐ Sulfa
☐ Tape
☐ Latex
☐ Codeine
☐ Iodine on Skin
☐ Local Anesthetic
☐ Nausea From Anesthetic
☐ Anti-inflammatory Medication
☐ Other ____________________

____

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	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ None
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ None
Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ None
High Blood Pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ None
Thyroid Disorders	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ None
Other: ____________	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ None

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

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

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

Foot / Leg Injuries	☐ Past	☐ Current	Weak Ankles	☐ Past	☐ Current	Foot Skin Problems	☐ Past	☐ Current
Foot / Leg Surgery	☐ Past	☐ Current	Bunions	☐ Past	☐ Current	Unequal leg Length	☐ Past	☐ Current
Foot / Leg Cramps	☐ Past	☐ Current	Knee Pain	☐ Past	☐ Current	Foot / Leg Numbness	☐ Past	☐ Current
Foot Ulcers	☐ Past	☐ 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.	☐ Yes ☐ No
☐ **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

Phone Number ( )	☐ This is a mail order pharmacy

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**
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Asian
☐ African American(Non-Hispanic or Latino origin)
☐ Hispanic or Latino
☐ White(Non-Hispanic or Latino origin)
☐ 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:	Date
HISTORY REVIEWED BY:	

CARUSO
FOOT & ANKLE, LLC

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 your 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: Caruso Foot and Ankle at 2 Paragon Way Suite 400 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: ________________________

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I____________________________hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand that it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow- up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature____Date_______________

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