CARUSO
FOOT & ANKLE, LLC

PATIENT REGISTRATION FORM

Today's Date: ____/____/____ (Please Print)

PATIENT INFORMATION

Last Name	First Name	Middle Name	Mr. ☐ Mrs. ☐ Miss. ☐ Dr. ☐ Jr. ☐ Sr. ☐
Street Address		City	State / Zip Code
Home Phone	Mobile Phone	Work Phone	e-mail
Birth Date	Age	Social Security Number	Marital Status / Sex
Parent or Guardian (If patient is under 18 years of age)		Relationship to Patient	

INSURANCE INFORMATION

Primary Insurance	Policy Holder	Relationship to Policy Holder	Policy Holder's Birth Date
Policy Holder's Employer		Employer's Address	
Secondary Insurance	Policy Holder	Relationship to Policy Holder	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.

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone
Name of nearest relative not living with you	Address	Phone
Do you have a living will? ☐ Yes ☐ No		Do you have a Power of Attorney? ☐ Yes ☐ No
Do you have an advanced directive? ☐ Yes ☐ No		Power of Attorney Name

PHYSICIAN INFORMATION

Primary Care Doctor's Name		Date Last Seen	
Street Address	City	State	Phone

SPECIALIST TREATMENT

Specialist and condition being treated	Specialist and condition being treated	Specialist and condition being treated

Dr. Rose A. Caruso
2 Paragon Way (Suite 400) Freehold, NJ 07728
Phone (732) 366-9866 - Fax (732) 866-0006
www.carusofootandankle.com

CARUSO
FOOT & ANKLE, LLC

PATIENT NAME: _____ BIRTH DATE ____/____/____

CHIEF COMPLAINT

What is the reason for today's visit?	Duration of symptoms (months / years)

BASELINE INFORMATION

Shoe size	Height	Weight	Blood sugar	Last blood pressure

Do you smoke now? ☐ Yes ☐ No	Packs/day now
Did you smoke previously? ☐ Yes ☐ No	Packs/day previously
Do you drink alcohol? ☐ Yes ☐ No	On average, how many drinks/week?

ALLERGIES

☐ No known allergies	☐ Penicillin	☐ Sulfa	☐ Tape	☐ Latex
☐ Codeine	☐ Iodine on skin	☐ Local anesthetic	☐ Nausea from anesthetic	☐ Anti-inflammatories

☐ Other

FOOT OR LEG CONDITIONS PAST OR PRESENT

☐ Foot or leg injuries	☐ Weak ankles	☐ Foot skin problems
☐ Foot or leg surgery	☐ Bunions	☐ Unequal leg length
☐ Foot or leg cramps	☐ Knee pain	☐ Foot or leg numbness
☐ Foot ulcers	☐ Other foot or leg problems	

Have you had past treatment from a podiatrist? ☐ Yes ☐ No	For What?

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

PAST SURGICAL HISTORY

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

Please list any past surgeries you've had

Dr. Rose A. Caruso
2 Paragon Way (Suite 400) Freehold, NJ 07728
Phone (732) 366-9866 - Fax (732) 866-0006
www.carusofootandankle.com

CARUSO
FOOT & ANKLE, LLC

PATIENT NAME: _____ BIRTH DATE ____/____/____

GENERAL CONDITIONS PAST OR PRESENT			
Arthritis:	☐ Yes ☐ No	Hepatitis (Type ____):	☐ Yes ☐ No
If yes, Rheumatoid Arthritis:	☐ Yes ☐ No	High Blood Pressure:	☐ Yes ☐ No
If yes, 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:	

FAMILY HISTORY	
Cancer:	Mother ☐ Father ☐ Sister(s) ____ ☐ Brother(s) ____ ☐ None
Diabetes:	Mother ☐ Father ☐ Sister(s) ____ ☐ Brother(s) ____ ☐ None
Heart Disease:	Mother ☐ Father ☐ Sister(s) ____ ☐ Brother(s) ____ ☐ None
High Blood Pressure:	Mother ☐ Father ☐ Sister(s) ____ ☐ Brother(s) ____ ☐ None
Thyroid Disorders:	Mother ☐ Father ☐ Sister(s) ____ ☐ Brother(s) ____ ☐ None
Other:	

Dr. Rose A. Caruso
2 Paragon Way (Suite 400) Freehold, NJ 07728
Phone (732) 366-9866 - Fax (732) 866-0006
www.carusofootandankle.com

CARUSO
FOOT & ANKLE, LLC

PATIENT NAME: _____ BIRTH DATE ____/____/____

MEDICATIONS

Please list all current medications you are taking, both prescription and over-the-counter (OTC)

I give Caruso Foot & Ankle permission to access my medical records electronically. ☐ Yes ☐ No

Please check here if you are not taking any medications. ☐

Medication	Dosage

PHARMACY INFORMATION

Preferred pharmacy

Address	City	State	Zip Code
Phone	☐ This is a mail order pharmacy		

DEMOGRAPHIC INFORMATION

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

Dr. Rose A. Caruso
2 Paragon Way (Suite 400) Freehold, NJ 07728
Phone (732) 366-9866 - Fax (732) 866-0006
www.carusofootandankle.com

CARUSO
FOOT & ANKLE, LLC

PATIENT NAME: _____ BIRTH DATE ____/____/____

REFERRAL INFORMATION	
☐ Doctor:	☐ Family:
☐ Hospital:	☐ Friend:
☐ Insurance Plan:	☐ Google/Internet:
☐ Social Media:	☐ AI (ChatGPT, Claude, Etc.):

ACKNOWLEDGEMENT

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

Dr. Rose A. Caruso
2 Paragon Way (Suite 400) Freehold, NJ 07728
Phone (732) 366-9866 - Fax (732) 866-0006
www.carusofootandankle.com

CARUSO
FOOT & ANKLE, LLC

PATIENT NAME: _____ BIRTH DATE ____/____/____

TERMS AND CONDITIONS OF TREATMENT

The undersigned acknowledges and agrees to the following:

1. Financial Responsibility

I understand that I am responsible for all amounts designated as patient responsibility by my insurance plan, including deductibles, co-payments, and co-insurance. If a service is non-covered or coverage is denied due to lack of authorization, referral, eligibility, expired coverage, or failure to comply with plan requirements, I understand that I may be responsible for the applicable charges, subject to applicable contractual and legal limitations. I agree to provide current and accurate insurance information at each visit. All patient responsibility amounts are due at the time of service unless prior arrangements have been made. **Returned checks are subject to a $50.00 fee.** Balances not paid within sixty (60) days may be considered delinquent and subject to collection procedures.

2. Missed Appointments

I understand that missed appointments limit access to care for other patients. **A $25.00 fee will be charged for appointments not cancelled at least 24 hours in advance.** Outstanding no-show fees must be paid before future appointments may be scheduled.

3. Forms and Medical Records

I understand that completion of forms, dictated letters, and preparation of medical records requires administrative time. Charges for such services will be assessed in accordance with office policy and applicable law.

4. Assignment of Benefits and Authorization to Release Information

I authorize Caruso Foot & Ankle LLC to release medical information necessary to process insurance claims and secure payment for services rendered. I authorize payment of medical benefits directly to Caruso Foot & Ankle LLC. I understand that I remain financially responsible for any balance not covered by insurance, subject to applicable contractual and legal limitations. A photocopy of this authorization shall be considered as effective as the original.

5. HIPAA Consent for Treatment, Payment, and Healthcare Operations

I consent to the use and disclosure of my Protected Health Information (PHI) by Caruso Foot & Ankle LLC for purposes of treatment, payment, and healthcare operations, as described in the Notice of Privacy Practices.

Dr. Rose A. Caruso
2 Paragon Way (Suite 400) Freehold, NJ 07728
Phone (732) 366-9866 - Fax (732) 866-0006
www.carusofootandankle.com

CARUSO
FOOT & ANKLE, LLC

PATIENT NAME: _____ BIRTH DATE ____/____/____

I understand that:

- I may review the Notice of Privacy Practices prior to signing.
- The practice may revise its Notice of Privacy Practices at any time.
- I may request restrictions on certain uses or disclosures.
- I may revoke this consent in writing, except to the extent that disclosures have already been made in reliance upon this consent.

If I decline to sign this consent, the practice may be unable to provide treatment.

6. Authorization to Discuss PHI with Designated Individuals

In addition to disclosures permitted for treatment, payment, and healthcare operations, I authorize Caruso Foot & Ankle LLC to discuss my Protected Health Information (PHI) with the individuals identified below. This authorization applies to verbal, written, and electronic communications.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

☐I do NOT authorize disclosure of my PHI to any person other than myself, except as permitted or required by law.

This authorization remains in effect unless revoked in writing.

7. Patient Responsibilities and Compliance with Treatment

I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the outcome of my treatment. I acknowledge that successful medical care depends in part upon my cooperation and compliance with medical advice, prescribed medications, recommended follow-up appointments, and diagnostic testing. If I am referred to a specialist or advised to obtain diagnostic testing, I understand that timely completion of such recommendations is important to my care. I agree to follow the medical advice provided to me and to notify the office of any changes in my condition. I understand that failure to follow medical advice or recommended evaluations may adversely affect my health or treatment outcome.

CARUSO
FOOT & ANKLE, LLC

PATIENT NAME: _____ BIRTH DATE ____/____/____

8. Medication Responsibility

If medication is prescribed to me, I understand that I am responsible for taking the medication as directed and following the prescribed dosage and frequency. I agree to notify the practice of any adverse reactions, side effects, or concerns related to my medication. I understand that failure to take medication as prescribed may adversely affect my health or treatment outcome.

9. Termination of Care

Caruso Foot & Ankle LLC reserves the right to initiate termination of the physician-patient relationship in accordance with New Jersey law (N.J.A.C. 13:35-6.22) for reasons including, but not limited to, delinquent accounts, failure to comply with office policies, disruptive or inappropriate behavior, repeated non-compliance with treatment recommendations, or circumstances that impair the provider-patient relationship.

In such cases, written notice will be provided, emergency care will be available for thirty (30) days from the date of notice, and medical records will be transferred upon written authorization. Termination will not occur for discriminatory reasons.

ACKNOWLEDGMENT

I certify that I have read and understand the Terms and Conditions of Treatment set forth above and have had the opportunity to ask questions. I acknowledge that these terms apply to all services provided by Caruso Foot & Ankle LLC.

Signature of Patient or Legal Guardian: _____

Printed Name: _____

Date: _____

Legal Guardian Name (if applicable): _____

Dr. Rose A. Caruso
2 Paragon Way (Suite 400) Freehold, NJ 07728
Phone (732) 366-9866 - Fax (732) 866-0006
www.carusofootandankle.com