



## PATIENT REGISTRATION FORM

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

(Please Print)

PATIENT INFORMATION						
Last Name	First Name	Middle Name	Mr.	Mrs.	Miss.	Dr.
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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		
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have a Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have an advanced directive? <input type="checkbox"/> Yes <input type="checkbox"/> 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		



PATIENT NAME: \_\_\_\_\_

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>CHIEF COMPLAINT</b>				
What is the reason for today's visit?			Duration of symptoms (months / years)	
<b>BASELINE INFORMATION</b>				
Shoe size	Height	Weight	Blood sugar	Last blood pressure
Do you smoke now? <input type="checkbox"/> Yes <input type="checkbox"/> No			Packs/day now	
Did you smoke previously? <input type="checkbox"/> Yes <input type="checkbox"/> No			Packs/day previously	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			On average, how many drinks/week?	
<b>ALLERGIES</b>				
<input type="checkbox"/> No known allergies	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Tape	<input type="checkbox"/> Latex
<input type="checkbox"/> Codeine	<input type="checkbox"/> Iodine on skin	<input type="checkbox"/> Local anesthetic	<input type="checkbox"/> Nausea from anesthetic	<input type="checkbox"/> Anti-inflammatories
<input type="checkbox"/> Other				
<b>FOOT OR LEG CONDITIONS PAST OR PRESENT</b>				
<input type="checkbox"/> Foot or leg injuries	<input type="checkbox"/> Weak ankles		<input type="checkbox"/> Foot skin problems	
<input type="checkbox"/> Foot or leg surgery	<input type="checkbox"/> Bunions		<input type="checkbox"/> Unequal leg length	
<input type="checkbox"/> Foot or leg cramps	<input type="checkbox"/> Knee pain		<input type="checkbox"/> Foot or leg numbness	
<input type="checkbox"/> Foot ulcers	<input type="checkbox"/> Other foot or leg problems			
Have you had past treatment from a podiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No			For What?	
What previous treatments have you had on your foot/ankle? <input type="checkbox"/> Surgery <input type="checkbox"/> Orthotics <input type="checkbox"/> Oral Medications <input type="checkbox"/> Cortisone Shots				
<b>PAST SURGICAL HISTORY</b>				
Have you ever been put to sleep for surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please list any past surgeries you've had				



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GENERAL CONDITIONS PAST OR PRESENT	
Arthritis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type ____): <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
If yes, 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:
FAMILY HISTORY	
Cancer:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister(s) ____ <input type="checkbox"/> Brother(s) ____ <input type="checkbox"/> None
Diabetes:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister(s) ____ <input type="checkbox"/> Brother(s) ____ <input type="checkbox"/> None
Heart Disease:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister(s) ____ <input type="checkbox"/> Brother(s) ____ <input type="checkbox"/> None
High Blood Pressure:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister(s) ____ <input type="checkbox"/> Brother(s) ____ <input type="checkbox"/> None
Thyroid Disorders:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister(s) ____ <input type="checkbox"/> Brother(s) ____ <input type="checkbox"/> 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](http://www.carusofootandankle.com)



PATIENT NAME: \_\_\_\_\_

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>MEDICATIONS</b>			
<b>Please list all current medications you are taking, both prescription and over-the-counter (OTC)</b>			
I give Caruso Foot & Ankle permission to access my medical records electronically. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please check here if you are not taking any medications. <input type="checkbox"/>			
Medication		Dosage	
<b>PHARMACY INFORMATION</b>			
Preferred pharmacy			
Address		City	State
Phone		<input type="checkbox"/> This is a mail order pharmacy	
<b>DEMOGRAPHIC INFORMATION</b>			
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	<input type="checkbox"/> 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"/> Asian	
	<input type="checkbox"/> African American (Non-Hispanic or Latino origin)	<input type="checkbox"/> Hispanic or Latino	
	<input type="checkbox"/> White (Non-Hispanic or Latino origin)	<input type="checkbox"/> Other	
Primary Language			



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REFERRAL INFORMATION	
<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"/> Social Media:	<input type="checkbox"/> 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



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.

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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.

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### **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): \_\_\_\_\_