RECONSTRUCTIVE FOOT AND ANKLE SURGICAL ASSOCIATES, P.C.
1600 N. High Street, Millville, NJ 08332 - Tel. (856) 825-9009 - Fax. (856) 825-4766
Jose R. Ruiz, DPM, FACFAS

PATIENT INFORMATION

First Name, Last Name	SSN	Birth Date	Sex M/F	Home Phone ( )	Cell Phone ( )

Mailing Address	City	State	Zip Code+4 digits	Martial Status Divorced/Married/Single/Widow

Employer	City	State	Zip Code	Work Phone

Race Asian/ Black/ Hispanic/ White	Ethnicity (Cultural Heritage)	Preferred Language English/ Other/ Sign Language/ Spanish

E-mail address

RESPONSIBILE PARTY (Name of Insured if other than patient OR if patient is a minor, **parent/guardian information** must be provided)

Relationship of Responsible Party to Patient

First Name, Last Name	SSN	Birth Date	Sex M/F	Home Phone ( )	Cell Phone ( )

Mailing Address	City	State	Zip Code	Martial Status Divorced/Married/Single/Widow

Employer	City	State	Zip Code	Work Phone

INSURANCE INFORMATION

Name of Primary Insurance Carrier	Policy/ID Number	Group Number	Relationship of insured to patient

Name of Secondary Insurance Carrier	Policy/ID Number	Group Number	Relationship of insured to patient

OTHER MEDICAL PROVIDER INFORMATION

Primary Care Physician	City	Phone

Referring Physician	City	Phone

Endocrinologist	City	Phone

EMERGENCY CONTACT INFORMATION

Name of Contact	Relationship	Primary Phone Number	Secondary Phone Number

RELEASE OF PERSONAL INFORMATION: I authorize the doctors and staff of Reconstructive Foot & Ankle Surgical Associates to discuss my personal medical and/or financial information with the following person (s)

Name of Authorized Person	Relationship	Phone Number

☐ Yes ☐ No **I authorize Reconstructive Foot & Ankle Surgical Associates to leave messages on my answering machine regarding my personal medical and/or financial information**

I certify the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies for the purpose of filing and payment of medical claims. I authorize payment of medical benefits directly to the provider. I permit a copy of this release to be used in place of the original. I acknowledge I was provided with information regarding the Notice of Privacy Practices and upon request a copy will be provided to me.

PLEASE PRESENT YOUR PHOTO ID AND MEDICAL INSURANCE WHEN COMPLETING THIS PAGE

Signature of Patient/Responsible Party **Date**

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The following is a statement of our financial policy that we require you to read and sign

REGARDING INSURANCE CLAIMS:
As a courtesy to our patients, we will bill your insurance company for services rendered. You must provide us with the **correct and complete insurance information** at the time of service. However, since your insurance policy is an agreement between you and your insurance company, if for any reason your insurance company does not pay your claim, you are financially responsible for the balance.

REGARDING PAYMENT:
All co-payments and unpaid deductibles are due at the time of service. We accept cash, personal checks, debit and credit cards. Please note, there is a **$25.00 fee for returned checks**, which must be paid in cash prior to continued treatment.

REGARDING MEDICARE:
We do accept Medicare assignment however, if you have not met **your deductible** for the current year, this will be **your responsibility** on your first visit with our office. Also, if you do not have a supplemental or secondary insurance, the **20%** Medicare does not cover will be **your responsibility** at the time of your visit.

REGARDING REFERRALS AND AUTHORIZATIONS:
If your insurance requires referral or prior authorization, it is the patient's responsibility to obtain it prior to the visit. You are required to show your ID card, insurance card and evidence of your referral and/or authorization in addition of your co-payment every time you come to the office.

REGARDING MISSED APPOINTMENTS:
When a patient misses a scheduled appointment, it deprives our office the opportunity to provide services to others needing our care. **We require 24 hours prior notice to cancel or re-schedule an appointment**. Failure to do this will result in a **$25.00 fee** charged to the patient, not the insurance company. This must be paid prior to continued treatment and services. In addition, if you arrive more than 15 minutes late for your appointment, we reserve the right to change your appointment for another day.

DURABLE MEDICAL EQUIPMENT (DME)/OVER-THE-COUNTER PRODUCTS:
We will **attempt to bill your insurance** company for DME, but not all insurance plans cover DME and it will be your responsibility to pay any **co-insurance, deductibles or balances** due. Also, as a convenience to our patients, we carry many products that **are not billable** to insurance companies as they are considered **over-the-counter products**. Payment is expected at the time of purchase.

Thank you for reading our financial policy. If you are unclear on any of our policies, please ask for clarification. Our staff will be happy to assist you in any way possible.

I have read and understand the financial policies as described above.

_____

Signature of Patient/Responsible Party **Date**

PRINTED NAME OF PATIENT

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MEDICAL HISTORY - INITIAL VISIT

Patient: _____ Date of Birth: _____ Date:_____

Services performed at: ☐ Office ☐ Home ☐ Nursing Home ☐ Assisted Living Facility ☐ Other _____

What is the reason of your visit?_____

Describe your foot problems and/or symptoms:

Ankle Pain	☐ Yes ☐ No	Heel Pain	☐ Yes ☐ No
Corn and calluses	☐ Yes ☐ No	Feet Swelling	☐ Yes ☐ No
Flat Feet	☐ Yes ☐ No	Bunions	☐ Yes ☐ No
Plantar Wart	☐ Yes ☐ No	Numbness in feet/legs	☐ Yes ☐ No
Athlete's Foot	☐ Yes ☐ No	Ingrown Toenails	☐ Yes ☐ No
Cramps in feet/legs	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No

Other: _____

List any past surgical procedures on your feet or ankles and approximate dates:

1.) _____ Date: _____

2.) _____ Date: _____

Shoe size: _____ Special shoes? _____ Current weight:_____ lbs. Height: _____ ft. _____in.

Do you use? Walker: ☐ Yes ☐ No Crutches: ☐ Yes ☐ No Cane: ☐ Yes ☐ No Wheel Chair: ☐ Yes ☐ No

Are you allergic or sensitive to:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetic

☐ Sulfa drugs ☐ No allergies to Food or Drugs ☐ If you are allergic to any or other, what type of reaction? _____

Pharmacy: _____ Address: _____

Medication List: ☐ **See attached list:**

Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____

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Patient: _____ **Date**: _____

Do you have or have you had any of the following conditions? Please check Yes or NO below

CONSTITUTIONAL

Appetite loss	☐Yes	☐ No	Chills	☐Yes	☐ No	Dizziness	☐Yes	☐ No
Fatigue	☐Yes	☐ No	Fever	☐Yes	☐ No	Night sweats	☐Yes	☐ No
Sleep Disturbances	☐Yes	☐ No	Weight loss/gain	☐Yes	☐ No	Other _____		

HEAD, EYES, EARS, NOSE AND THROAT

Eye Problems	☐Yes	☐ No	Hearing problems	☐Yes	☐ No	Nose bleeds	☐Yes	☐ No
Throat Problems	☐Yes	☐ No	Other _____					

CARDIOVASCULAR

Angina	☐Yes	☐ No	Artificial heart valve	☐Yes	☐ No	Blood clots	☐Yes	☐ No
Blood transfusion	☐Yes	☐ No	Chest pain	☐Yes	☐ No	Cold hands or feet	☐Yes	☐ No
Deep Venous Thrombosis	☐Yes	☐ No	Heart Disease	☐Yes	☐ No	High blood pressure	☐Yes	☐ No
High cholesterol	☐Yes	☐ No	Irregular heartbeat	☐Yes	☐ No	Leg cramps	☐Yes	☐ No
Leg pain w/rest	☐Yes	☐ No	Leg pain w/walking	☐Yes	☐ No	Leg swelling	☐Yes	☐ No
Pacemaker	☐Yes	☐ No	Palpitations	☐Yes	☐ No	Peripheral vascular disease	☐Yes	☐ No
Poor Circulation	☐Yes	☐ No	Pulmonary Embolism	☐Yes	☐ No	Rheumatic Fever	☐Yes	☐ No
Stroke	☐Yes	☐ No	Varicose veins	☐Yes	☐ No	Other _____		

RESPIRATORY

Asthma	☐Yes	☐ No	Tuberculosis	☐Yes	☐ No	Emphysema	☐Yes	☐ No
Respiratory Problems	☐Yes	☐ No	Shortness of breath	☐Yes	☐ No	Sleep Apnea	☐Yes	☐ No
Chronic obstruction pulmonary disease (COPD)	☐Yes	☐ No	Other _____					

GASTROINTESTINAL

Blood in stool	☐Yes	☐ No	Constipation	☐Yes	☐ No	Diarrhea	☐Yes	☐ No
Gallbladder disease	☐Yes	☐ No	Heartburn	☐Yes	☐ No	Hepatitis A, B or C	☐Yes	☐ No
Hernia	☐Yes	☐ No	Liver disease	☐Yes	☐ No	Nausea	☐Yes	☐ No
Stomach pain	☐Yes	☐ No	Stomach ulcers	☐Yes	☐ No	Ulcer(s)	☐Yes	☐ No
Other _____								

NEUROLOGICAL

Burning sensation	☐Yes	☐ No	Fainting	☐Yes	☐ No	Foot Tingling	☐Yes	☐ No
Head injury	☐Yes	☐ No	Headaches	☐Yes	☐ No	Loss of balance	☐Yes	☐ No
Loss of sensation	☐Yes	☐ No	Memory Loss	☐Yes	☐ No	Numbness	☐Yes	☐ No
Recent falls	☐Yes	☐ No	Seizures	☐Yes	☐ No	Spine bifida	☐Yes	☐ No
Tremor	☐Yes	☐ No	Alzheimer	☐Yes	☐ No	Other _____		

MUSCULOSKELETAL

Arthritis	☐Yes	☐ No	Back pain	☐Yes	☐ No	Fractures	☐Yes	☐ No
Gout	☐Yes	☐ No	Joint Replacement	☐Yes	☐ No	Joint pain	☐Yes	☐ No
Joint swelling	☐Yes	☐ No	Leg pain	☐Yes	☐ No	Osteoporosis	☐Yes	☐ No
Other _____								

GENITOURINARY

Kidney Disease	☐Yes	☐ No	Nocturia	☐Yes	☐ No	Renal dialysis	☐Yes	☐ No
Sexually transmitted Disease	☐Yes	☐ No	Other _____					

INTEGUMENTARY

Herpes	☐Yes	☐ No	Rash	☐Yes	☐ No	Toenail problems	☐Yes	☐ No
Skin cancer	☐Yes	☐ No	Skin discoloration	☐Yes	☐ No	Skin Problems	☐Yes	☐ No
Skin ulcers	☐Yes	☐ No	Other _____					

PSYCHIATRIC

Anxiety	☐Yes	☐ No	Depression	☐Yes	☐ No	Drug Addiction	☐Yes	☐ No
Other _____								

HEMATOLOGIC/LYMPHATIC

Anemia	☐Yes	☐ No	Cancer treatment	☐Yes	☐ No	Excessive bleeding	☐Yes	☐ No
Hemophilia	☐Yes	☐ No	HIV/AIDS	☐Yes	☐ No	Leukemia	☐Yes	☐ No
Sickle cell anemia	☐Yes	☐ No	Unexplained bruising	☐Yes	☐ No	Other _____		

ENDOCRINE

Diabetes	☐Yes	☐ No	Hypoglycemia	☐Yes	☐ No	Thyroid Disorder	☐Yes	☐ No
Other _____								

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Patient: _____ **Date**: _____

Do you have Diabetes? ☐ Yes ☐ No **If yes, do you take insulin?** ☐ Yes ☐ No

When diagnosed: _____ Treating physician: _____

Date of last treatment: _____

List any serious illness: _____

List any major surgeries: _____

Are you presently under a physician's care: ☐ Yes ☐ No **If so, please list the condition being treated and the physician:**

Condition: _____ Physician: _____

Condition: _____ Physician: _____

Social History:

Do you smoke? ☐ Yes ☐ No If so, number of cigarette packs per day _____ For how long? _____

Have you previously smoked? ☐ Yes ☐ No If so, when did you quit? _____

Consume Alcohol? ☐ Yes ☐ No If so, drinks/week: _____

Do you exercise? ☐ Yes ☐ No If so, describe activities and frequencies: _____

Family History:

Mother: Living ____ Deceased ____ Cause of death _____

Father: Living ____ Deceased ____ Cause of death _____

Brother(s): Number ____ How many living ____ Causes of deaths _____

Sister(s): Number ____ How many living ____ Causes of deaths _____

Any family history of the following diseases? If so, which family member?

	MOTHER	FATHER	BROTHER	SISTER
Heart Disease	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Bleeding disorder	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Neurologic Disorder	_____	_____	_____	_____
Circulation problems	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Vascular disorders	_____	_____	_____	_____