SCOTT SHREM D.P.M.
Garden State Foot & Ankle Center
The American Board of Podiatric Medicine

226 Middle Rd Suite 7
Hazlet, NJ 07730
Phone: (732) 264-3668
Fax: (732)264-0101

PATIENT INFORMATION SHEET

Date: ___________ Last Name: _________________________ First Name: _______________________ Middle Initial: ______

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed Race/Ethnicity: ______________________

Social Security # _______-_____-_________ Birth Date: _________________ Age: ______ Preferred Name: _____________

Street: ____ City: ____________________ State: ______ Zip____________

Cell Phone: (______) _________________________ Home Phone: (______) __________________________

Work Phone: (______) ________________________ E-Mail: ____

Responsible Party (if patient is a minor): _____________________________________ Relationship: _____________________

Emergency Contact: __________________________ Phone: (______) _________________Relationship: _________________

Pharmacy Name: ____ Address: _______________________________________

Pharmacy Phone: (______) ___________________________

INSURANCE INFORMATION:

Do you have Medical Insurance? □ Yes □ No Insurance Plan Name: ____

Secondary Insurance Plan (if applicable): ____

Who is your primary care Physician? _______________________________ Physician Phone: (______) ___________________

Office Location: ____
City/Town/State

EMPLOYMENT INFORMATION:

Occupation: ____ Employer: _____________________________________

Business Address: ____

HISTORY:

Weight __________ lbs Height ______ft _____inch Last Known Blood Pressure: ___________ Shoe Size: ______________

Current Foot/Ankle Problem: ____

Describe your pain: _________________________________ What makes it better / worse: ___________________________

Diabetics Only: Last Blood Sugar: ___________________________ HBA1C:____

Woman Only Are you pregnant / nursing: ____

Ever Been to a Foot Doctor Before? _________________ For What? ____

How did you find out about us? ____

Exercise type if applicable: ____

SIGNATURE OF PATIENT: ____

SCOTT SHREM D.P.M.
Garden State Foot & Ankle Center

The American Board of Podiatric Medicine

226 Middle Rd Suite 7
Hazlet, NJ 07730
Phone: (732) 264-3668
Fax: (732) 264-0101

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it (*Notice of Privacy Practices*) from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ________________________________ Date: ___________________

I authorize my physician and/or clinical staff to disclose my health information to:

Myself and Other: __________________________ Phone (___) ______________

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my insurance companies
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance company
- I authorize direct payment to my doctor
- I authorize my medical records to be released to my primary care doctor
- I authorize permission for any appeals done on my behalf to my insurance company
- I understand that I am fully responsible for my bill if denied by my insurance company
- I understand that I am fully responsible for obtaining any referrals required by my insurance company and being aware that all referrals are made out appropriately to my doctor

Patient Name: ____

Relationship to Patient: ____

Signature: ________________________________ Date: ___________________

SCOTT SHREM D.P.M.
Garden State Foot & Ankle Center
The American Board of Podiatric Medicine

226 Middle Rd Suite 7
Hazlet, NJ 07730
Phone: (732) 264-3668
Fax: (732)264-0101

Medical History (check all that apply)

- ○ Anemia
- ○ Cancer
- ○ Cardiac Disease
- ○ Chronic Renal Dz
- ○ Congestive Heart Fail
- ○ COPD
- ○ Diabetes Mellitus
- ○ Hypertension
- ○ Kidney Disease
- ○ M.I. (Heart Attack)
- ○ Obesity
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Peripheral Vascular D
- ○ Rheumatoid Arthritis
- ○ Stroke
- ○ Tuberculosis
- ○ AIDS/HIV
- ○ Gout
- ○ Hepatitis / Liver Dz
- ○ Fibromyalgia / RSD
- ○ Stomach Ulcers
- ○ Sciatica
- ○ Nerve Disorder

Other:____

____

Social History

Alcohol Use: Daily / Occasionally / Recreational   Tobacco: Never / Former / Current # Packs Per Day:____________________

Recreational Drug User: Never / Former / Current Type:________________   Occupation:______________________________

Past Surgical History

____

____

Family History

Father: ____   Mother: ____

Brothers: ______________________________________   Sisters: ____

Medications & Dosages

____

____

Allergies to Medications

____

____

Review Of Systems (check all that apply)

- ○ Fevers, chills
- ○ Recent weight gain or loss
- ○ Vision changes
- ○ Ears, nose, mouth or throat complaints
- ○ Chest pain, fast heart rate
- ○ Shortness of breath, persistent coughing
- ○ Stomach Upset, diarrhea, constipation
- ○ Painful urination, increased or decrease frequency
- ○ Skin rashes, lesion, or easy bruising
- ○ Pins and needles sensation in hands or feet, tremors
- ○ Depression, mood swings, sleep disturbance
- ○ Swollen hands or feet
- ○ Blood in urine or stool
- ○ Bone or joint pain
- ○ Frequent Sneezing, watery eyes
- ○ Other: ________________________________
- ○ Other: ________________________________

SIGNATURE OF PATIENT: ____