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: _____

Occupation: _____ Birth Date: _____ Age: _____ Email:_____

Street: _____ City _____State:_____ Zip_____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Responsible Party (if patient is a minor): _____ Relationship: _____

Emergency Contact: _____ Phone: (_____) _____Relationship: _____

Pharmacy Name/Address: _____ Pharmacy Phone: (_____) _____

MEDICAL DOCTOR INFORMATION:

Who is your primary care physician? _____ Physician Phone: (_____) _____

Office Location: _____
City/Town/State

EMPLOYMENT INFORMATION:

Occupation: _____ Patient employed by: _____

Business Address: _____

MEDICAL HISTORY: Weight _____ lbs Height _____ Last Known Blood Pressure: _____ Shoe Size: _____

Current Foot/Ankle Problem_____

Do you have or have you ever been treated for:

☐ GERD	☐ Heart Attack	☐ Arthritis	☐ Epilepsy
☐ Stomach Ulcer	☐ High Blood Pressure	☐ Osteoprosis	☐ Fibromyalgia/RSD
☐ Liver Disease	☐ High Cholesterol	☐ Gout	☐ Stroke
☐ Hepatitis	☐ Arrhythmia	☐ Poor Circulation	☐ Hearing/Ear Disorder
☐ AIDS/HIV	☐ Valvular Heart Dz	☐ Kidney Disease	☐ Glaucoma
☐ Hypothyroid	☐ Asthma	☐ Anemia	☐ Nerve Disorder
☐ Hyperthyroid	☐ Lung Disease	☐ Psychiatric Disorder	☐ Sciatica
☐ Diabetes	☐ Rheumatoid Athritis	☐ Alzheimers	☐ Cancer

Other Past Medical History Not Listed Above: _____

Past Surgical History: _____

_____

Allergies to Medications: _____

Current Medications: _____

_____

_____

Family Medical History: □ Diabetes □ Heart Disease □ Poor Circulation □ Blood Clots □ Foot Problems □ Stroke □ Melanoma

Social History: Smoking Status: □ Former □ Current □ Never Drink Alcohol Regularly? □ Yes □ No

Recreational Drug Abuse? □ Former □ Current □ Never

Who Can We Thank For Your Referral: _____

SIGNATURE OF PATIENT: _____

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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: _____