Patient Intake Questionnaire

Name: ________________________________ **Today's Date**_____________

Reason for This Visit: ____
____

Date of Injury or Onset of Current Illness (How long has it bothered you?):
____

__auto accident __work related accident __sports injury __illness related problem
__other(please explain)
____
____
____

Current Symptoms: (Check all that apply)

__aching pain	__itching	__numbness	__nail discomfort
__ Dull pain	__tingling	__discoloration	__heel pain
__throbbing pain	__tenderness	__weakness	__dry skin
__sharp pain	__soreness	__sores	__toe discomfort
__corns	__bunions	__ulcers	__ingrown nails

__left foot- __big toe __2nd toe __3rd toe __4th toe __little toe
__heel __arch __ankle __the area between the toes

__right foot-__big toe __2nd toe __3rd toe __4th toe __little toe
__heel __arch __ankle __the area between the toes

Severity __ severe __moderate __mild __slight
Frequency __constant __frequent __occasional __intermittent
Have you been treated for this condition in the past?
__yes __no When? _____________________ By whom? ___________________________

What actions or movements make the condition worse?
____
Have you treated this condition? If yes, with what medication or device?________________
Are you having any other symptoms or problems? (Explain in detail below)
____
____

What foot conditions have you been treated for? (Check all that apply)

___ulcers	___fungal nails	___heel pain	___flat feet
___broken bones	___ingrown nails	___ankle pain	___neuroma
___hammertoe	___dry skin	___leg pain	___bunions
___warts	___numbness	___back pain	___diabetes
___corns/callus	___rashes	___gait problem	___circulatory problems

Other: (Explain in detail)
____
____

List any current allergies you have: (be specific)___________________________________
____
____

Past Medical History / Illnesses: (Check all that apply)

__diabetes	__arthritis	__stroke	__vascular disease
__anemia	__osteoporosis	__Alzheimer's	__kidney disease
__gout	__amputation	__ulcers	__high blood pressure
__sciatica	__cancer	__heart attack	__high cholesterol
__phlebitis	__liver disease	__thyroid disease	__psychiatric disorder

Other illnesses: ____

Are you now under active chemotherapy? ___yes ___no

What serious injuries have you had? Try to include the date of injury.
____

What surgeries or procedures have you had? What was the date of each surgery?____

Do you have vascular grafts? ___yes ___no

Do have joint implants? ___yes ___no

Do you have a replacement heart valve? ___yes ___no

When and for what conditions have you been hospitalized for?
____
____
____

List the medications you are taking: (be specific) __________________________________
____
____

List the relationship to you of your family members who have had:

Diabetes_________ arthritis_________ heart attack_________ stroke___________

High blood pressure_________ cancer___________- what type of cancer? ________

Other conditions____

Are you pregnant? ____yes ____no

Social History

Do you smoke now? ___no ___yes packs/ day ____ for how many years? ____

Did you ever smoke? ___yes ___no if you quit smoking when did you do so? _________

Do you drink alcoholic beverages? (Circle one) none rarely moderately daily quit

Do you use recreational drugs? (Circle one) none rarely moderately daily quit

Do you exercise? ___yes ___no, what type of exercise? ______________________________

Are there any other comments or contributing factors you would like to discuss?___________
____
____

Signature: ____ **Reviewed By:** _____________

Quality Foot Care Center
Harvey R. Jacobs DPM, FACFAS
25 Clyde Road, Suite 101
Somerset, New Jersey 08873
732-873-1111

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/in the or employee health care benefits coverage with_________________, and hereby assign and convey directly to Dr. Harvey Jacobs all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor or clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and or denial and if outside collection attempts are necessary, I will also be responsible for all collection in legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee benefits claim submissions.

I hereby conveyed to the above name doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as result of the medical services I received from the above named doctor and clinic and to the extent permissible in the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempt by such doctor and clinic to pursue such claim, chose in action or right against my insurers and or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of his assignment is to be considered as valid as the original. I have read and fully understand this agreement.

___________________________________ ____________

Signature of insured/Guardian Date

Relationship of Guardian to Minor Child: _______________________

Quality Foot Care Center
Harvey R. Jacobs DPM, FACFAS
25 Clyde Road, Suite 101
Somerset, New Jersey 08873
732-873-1111

Patient Registration Form

Date _______________

Last Name ________________ First Name__________________ Date of Birth _______

Home Address: Street___________________________ City__________________

State ________ ZIP code ______________

Home phone # ____________work phone #__________cell phone#___________

E-mail____________________

Marital status: single________ married __________ divorced_________

Your employer's name: ____________________Your employer's address:
____

Spouse's name: _______________________ employed by:
____

Spouse's employer's address: ____

Whom may we thank for referring you? _______________________________________

Name of your physician ____

Physician's phone number _____________and Fax number____________________

Physician's address ____

Pharmacy name and tel. number____

Pharmacy address____

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered.

If you have a managed-care type of insurance that requires referral for each office visit, it is your responsibility to obtain this referral before your visit. If you have not received the proper authorization, you will either not be seen or you will be responsible for the entire fee.

____ **Date**_________________________

Signature of patient or parent's signature

Quality Foot Care Center
Harvey R. Jacobs, D.P.M.
Marc J. Berman, D.P.M.
25 Clyde Road, Suite 101
Somerset, New Jersey 08873

Appointment Cancellation / No Show Policy Agreement:

Quality Foot Care Center is committed to providing all of our patients with exceptional care. When a patient no shows or cancels without giving enough notice, they prevent another patient from being treated.

Please call us at 732-873-1111 the day prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, you will be charged $25.00 for the missed appointment. Your insurance company is not responsible for the missed appointment fee.

Please sign below to consent to these terms.

____
Client Signature (Client's Parent/Guardian if under 18)

____
Date