

FEET 'N BEYOND OF NEW JERSEY, P.A.

HELENE T. NGUYEN, DPM ♦ YONG J. ZHU, DPM

57 Route 46 East, Suite 105
Hackettstown, NJ 07840

REGISTRATION (please print)

Tel: 908-576-0880

Facsimile: 908-576-0881

Date ___/___/2008 Home Phone (___) _____ Cell Phone (___) _____

May we leave message on your home phone ___Yes ___No and/Or On your cell phone ___Yes ___No

PATIENT'S INFORMATION __DR. __MR. __MRS. __MISS __STUDENT __MINOR

Name _____ Birthday ___/___/_____

Address _____ City _____

State _____ Zip _____ Email _____

Soc.Sec.# _____ Married Divorced Widow Single Minor

Employer name/School _____ Occupation _____

Employer/School Phone# _____

Primary Doctor _____ Phone (___) _____

Primary Doctor's address _____

When was the last date you saw your doctor ___/___/_____

In case of emergency who should be notified? _____ Phone (___) _____

Whom may we thank for referring you _____

The reason that bring you to the foot doctor today is/are _____

How long have you had this problem? ___ Days ___ Weeks ___ Months ___ Years

Was this problem treated? ___Yes ___No, If yes, what was done? _____

Past Medical & Podiatry history (please check all that applies to indicate if you or patient has the following)

___AIDS/HIV ___Anemia ___Arthritis ___Asthma ___Back problems/pain ___Bleeding Disorder

___Bruise easily ___Circulation problem ___Diabetes ___Eye/Ear problem ___Heart disease/attack(s)

___Heart bypass ___Hepatitis ___High blood pressure ___Kidney disease ___Leg cramps ___Liver disease

___Lung disease ___Tuberculosis ___Other _____

Current Medications _____

Do you have any allergies to medications or food? ___Yes___No, If yes, what are you allergic to? _____

Shoe Size _____ Weight_____ Height_____ Surgeries you have had _____

PRIVACY NOTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notices.

X

Patient's Name (Print) _____ (signature) _____ Date _____
(Parent/Guardian/Authorized representative's name if patient is a minor or patient is unable to fill out this form)

Under the Privacy Act and regulation by HIPAA: This office can not release any records regarding your treatments and/or medical status. There are situations; however, such as emergencies or legal proceedings where your medical records are needed...our office would like to know what you would like us to do in such situations.
Please choose below: ****

DO NOT release my medical records to anyone (including my family) under any circumstances which includes emergencies, legal proceedings, hospitalizations etc... (I will obtain my records in person by filling out a request)

I allow this office to release my medical records to my spouse and/or family without me being present—please provide us family members' name and their relation to you on the line provided below.
(Only the names listed will be allowed to access)

I allow this office to release my medical records to my attorney (provide Law firm's name and contact person phone #) _____

******Medical Documentation Release Policy: Feet 'N Beyond of NJ, P.A. reserve the right to hold and delay any request for a patient's medical records for 3 to 10 business days for review and/or consultation of our legal experts**

ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have insurance coverage and assign directly to Feet 'N Beyond of NJ, P.A. all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to my insurance company(ies), associated agent(s), and my primary / specialist physicians for the purpose of obtaining payment, determining insurance benefits, obtain pre-certification for treatment services, and coordinating care for my health welfare.

X _____
Patient's/Parent's/Guardian's or authorized representative's signature _____ Date _____

Please print name of signature _____ Relation to patient (if applicable) _____

