Practice: **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: _____ ☐Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

~~**Referring Physician:** _____ Phone: _____ Date Last Seen: _____~~

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other:

Name(s):_____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐No Known Medications ☐I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

☐No Known Allergies ☐No Known Drug Allergies

Name: _____ Reaction_____

Name: _____ Reaction_____

Name: _____ Reaction_____

Name: _____ Reaction_____

Name: _____ Reaction_____

Name: _____ Reaction_____

Name: _____ Reaction_____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Have you completed any Advanced Directives? ☐Yes ☐No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature _____ Date _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's _____ ☐ Depression _____
☐ Arthritis _____ ☐ Diabetes _____
☐ Bleeding disorders _____ ☐ Emphysema _____
☐ Blood clot _____ ☐ Heart disease _____
☐ Cancer _____ ☐ High Blood Pressure _____
☐ Cataracts _____ ☐ Neurological _____
☐ Circulation problems _____ ☐ Strokes _____
☐ Other (specify): _____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ constipation ☐ **NONE**
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ **NONE**
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis ☐ **NONE**
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
_____	_____	_____	

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ **Last four digits of SSN or other identifier:** _____
Print Name: _____ **Last four digits of SSN or other identifier:** _____
Print Name: _____ **Last four digits of SSN or other identifier:** _____

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:
_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Written Communication Address:
_____
____ OK to mail to address listed above
____ E-mail me at: _____

Work Telephone Number:
_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Fax Communication:
_____
____ OK to Fax at the number listed above
____ E-mail me at: _____

Other: _____

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):
Print Name: _____ **Print Name:** _____
Print Name: _____ **Print Name:** _____

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Name of Patient (Printed)	Signature of Patient	Date

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that North Jersey Podiatry can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to North Jersey Podiatry to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

_____

Patient Name (PLEASE PRINT)

_____ _____

Signature Date

Relationship to Patient: _____

Pharmacy (Name & Location) _____

Name:_____DOB:_____

I.D._____Date(s) of Service:_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL PLAN DOCUMENTS:

In considering the amount of medical expenses incurred, I the undersigned, have employee health care benefits coverage under my insurance plan, as per my employee benefit plan assign and convey directly to Paul G. Klein, DPM all medical benefits and/or insurance reimbursement otherwise payable to me for services rendered from such doctor.

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

I hereby convey to the above named doctor to the full extend permissible under the law in my prevailing state of NJ and under the applicable insurance policies and/or employee health care plan any claim, choice 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 a result of the medical services I received from Dr. Paul G. Klein, DPM. Additionally, I allow Dr. Paul G. Klein, DPM to claim such medical benefits, insurance reimbursement by any applicable remedies. I allow Dr. Paul G. Klein, DPM and his office(s) to receive all information regarding my claims by telephone conversation with representatives of my insurance carrier and by mail directly from the carrier.

Further, in response to any reasonable request for cooperation, I agree to cooperate with Paul G. Klein, DPM in any attempts 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's expenses. I assign Dr. Paul G. Klein, DPM and his designees including his attorney representative(s), and contracted collection agency all rights in appealing my unpaid and/or under paid claims. I acknowledge that Dr. Paul G. Klein, DPM may assign the appeal process to an outside attorney and/or collection agent in pursuing such appeals. This will action is taken with my full knowledge and consent for representation.

I further understand that I am responsible for deductibles and coinsurance amounts to be paid directly to Paul G. Klein, DPM.

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

It is understood that Dr. Paul G. Klein, DPM is to be paid directly for this claim by my insurance carrier shield at a NON-DISCOUNTED RATE as he does not have a contract to accept a negotiated rate with my carrier.

THIS IS A LEGAL ASSIGNMENT OF BENEFITS. PAYMENT IS TO BE MADE DIRECTLY TO DR. PAUL G. KLEIN, DPM, tax I.D. 22-2673170.

_____

Signature of Insured/Patient/Date Print Name