Camden County Foot and Ankle Associates

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Today's Date_____

Please fill out the following PAGES for your health records.
PLEASE PRINT CLEARLY
It is important to your care that you fill out ALL information to the best of your ability.

Name:_____ **Birth Date:** _____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home #: _____ **Cell #:** _____ **Work #:** _____

Social Security #: _____ **Email** (for Appointment Reminders):_____

Marital Status: M S W D **Ethnicity/Race:** _____ **Preferred Language:** _____

Occupation: _____ **Employer:** _____

Primary Physician: _____

Primary Physician's Phone #: _____ **Date Last Seen:** ____/____/_____

Parent/ Guardian Name (if the patient is under 18 years old): _____

Emergency Contact Person: _____ **Phone #:** _____

Relationship to Patient: _____

Insurance Information

If the subscriber to your insurance is not yourself (you are the subscriber's spouse or if the patient is a child)
PLEASE be sure to provide the subscribers name and date of birth as it may be needed for insurance billing purposes.

Primary Insurance Company: _____

Subscriber's Name: _____ **Relationship to Patient:** _____

Subscriber's Date of Birth: ____/____/_____ **Social Security #:** _____

Secondary Insurance Company: _____

Subscriber's Name: _____ **Relationship to Patient:** _____

Subscriber's Date of Birth: ____/____/_____ **Social Security #:** _____

Continued on Next Page

Patient Medical History

Please describe (in detail) the reason for your visit: _____

_____

How would you describe your pain? (Circle one)

Aching/Throbbing/Sharp/Pins and Needles/Electrical Sensation/Burning/Cramping/Numbness

When did this problem begin?:_____

Any previous treatment? (Please Describe)_____

Is your problem the result of trauma or injury? If yes, please explain: _____

_____

What activities aggravate your condition? _____

Is your condition worsening? _____

What is your activity level at work? (ie: Standing, Sitting, Walking, Retired);_____

Please describe any current medical problems even if they are being controlled by medication (i.e.: diabetes, heart conditions):

_____
_____
_____
_____

Have you ever been diagnosed with Hepatitis or other communicable blood disorders: Y ___ N____

If Yes, Please list:

_____

Please list your current medications: ***

*****(It is important that we know ALL of your current medications. If you are unable to remember or if you do not have a list available please call the office following your appointment with a complete list. Thank you.):**

_____
_____
_____
_____

Please list all allergies or adverse reactions to any medications <u>including the reaction you experienced</u>:

_____
_____
_____

Continued on Next Page

Patient Medical History Continued

Height: _____ Weight: _____ Shoe Size: _____

Most Recent Blood Pressure: _____

Diabetic Patients: Most recent blood sugar reading: _____

Pharmacy: Please tell us the name, phone number and address of the Pharmacy that you use. If you do not know the address, cross streets are sufficient.

_____

_____

Do you smoke? Yes_____ No_____ How much per day? _____

Do you drink? Yes_____ No_____ How much per day? _____ Per week? _____

Do you use illicit drugs? Yes_____ No_____ Please describe: _____

Please list all surgeries or hospitalizations (please include dates if you can):

_____

_____

_____

_____

Please list your family's medical history (i.e. diabetes, stroke, heart disease, migraines, etc):
(Please include your relationship to the family member)

_____

_____

_____

_____

How were you referred to our office?

Physician? **Physician's Name: _____**

Family or Friend? **Family or Friend's Name: _____**

Internet? (circle one) **Google / Yahoo / Bing / SuperClicks (superpages.com)/**

Insurance Website / Phone book/ Facebook / ZocDoc

Advertisement? **Mailbox Post Card**

Other? **Please Describe: _____**

Continued on Next Page

Office Policy Regarding Insurance Assignment

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY!!!

1. **I understand that I am required to pay my co pay, deductible and co insurance BEFORE services are rendered. All deductibles, co pays or co-insurance are due at the time of your visit. Acceptable methods of payment are cash, checks and credit/debit cards.**

2. **I understand that I am solely responsible for acquiring referrals from my primary doctor PRIOR to my appointment, and knowing how many visits I have been issued. If a referral was not issued, I will pay all fees for that date of service. If I do not have my referral my visit is considered NOT COVERED by my insurance, my claim will be denied and I will be responsible for the cost of the visit.**

3. **The physician's office does not guarantee that my insurance will pay for services. The office staff will make every attempt to receive the benefits of my policy; however, the staff is warned by every insurance company that there is NO GUARANTEE of payment even if they are told services are covered. Therefore, it is solely my responsibility to know the benefits of my insurance policy. If insurance claims are denied I will be responsible for the full amount of my bill.**

4. **The physician's office will NOT enter into a dispute with my insurance company over my claim. It is my responsibility to contact my insurance company and review my claim.**

5. **If my insurance company requests medical information from this physician's office in order to process a claim, the office staff will submit the requested documentation.**

6. **The following statement applies to me:**

   _____ Yes, I have been associated with a malpractice suit.
   _____ No, I have never been associated with a malpractice suit.

7. **I consent to evaluation and treatment by the physician. If I have any questions or concerns, I will ask prior to any treatment.**

By signing my name below, I indicate that I have fully read and understand the Office Policy Regarding Insurance Assignment.

_____

Name (please print)

_____ _____

Signature **Date**

Continued on Next Page

Authorization for Release of Medical Records

I hereby authorize my primary physician to disclose (if necessary) to Camden County Foot and Ankle Associates any information which they have obtained by examination. By signing this I release them of any consequence.

Primary Physician: _____

Signature: _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was provided a written copy of the Notice of Privacy Practices. I was given the opportunity to read and understand the notice fully.

_____ _____

Patient's Name (Please Print) **Date**

_____

Parent or Authorized Representative

_____

Signature

Continued on Next Page

Camden County Foot and Ankle Associates LLC

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Understanding Our Cancellation Policy

Our goal at Camden County Foot and Ankle Associates is to provide quality podiatric care in a timely manner. In order to do so we have an appointment cancellation policy in place. We ask that you show consideration by notifying our office at least 48 hours in advance if you are unable to keep your appointment. This permits us to better serve you, our patients, by allowing us to adjust our schedule if necessary. Appointments are in extremely high demand. Your early cancellation will give another patient the possibility to have access to timely medical care.

If you fail to give 48 hours notice for a cancelled appointment or just do not show up, there will be a $55.00 fee charged to your account. This fee is NOT covered by your insurance and will be your responsibility to pay. We strive to accommodate all of our patients and we understand when an emergency or sudden illness may arise. So in these special circumstances your fee may be waived.

As a reminder, you can call our office 24/7 to cancel your appointment. If you do not reach a live person when you call, we encourage you to leave a detailed message on our voicemail and one of us will return your call when it is received to reschedule.

Again, we value and appreciate every one of our patients and thank you very much for your understanding and cooperation.

_____	_____	_____
Patient's Name (Please Print)	Patient's Signature	Date

_____	_____
Witness Signature	Date