



THE FOOT & ANKLE CENTRE OF N.J., P.A. EMANUEL M. HABER, DPM

Please take a few minutes to answer the following questions
so we can better assist you with your health care needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Cell Phone # _____
Last Name First Name Initial
Address _____ Home Phone _____
City _____ State _____ Zip _____
Sex: () M () F () Minor () Single () Married () Divorced () Widowed () Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Whom may we thank for referring you? _____
In case of emergency, whom should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I. D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

PLEASE COMPLETE REVERSE SIDE

REASON FOR VISIT

Please list your present health concerns, problems or symptoms relating to your feet: _____

MEDICAL HISTORY

When was your last physical exam? _____

Physician's Name _____ Phone _____

Your drugstore / pharmacy : _____ Phone _____

1. Are you currently under medical treatment?.....()Yes ()No
following:
Please describe: _____
2. Have you ever had any serious illnesses or operations?.....()Yes ()No
Please describe: _____
3. Are you currently taking any medication?.....()Yes ()No
Please describe: _____
4. Do you smoke?.....()Yes ()No
5. Do you use alcohol, cocaine, or other drugs?.....()Yes ()No
6. Have you had any allergic reactions to the
following:

	YES	NO
Local Anesthetics (eg. Novacaine).....() ()		
Penicillin or other Antibiotics..... () ()		
Sulfa Drugs.....() ()		
Barbiturates (sleeping pills).....() ()		
Sedatives..... () ()		
Iodine.....() ()		
Aspirin.....() ()		
Other.....() ()		

Have you ever had the following:

	Yes	No		Yes	No		Yes	No
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care.....	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Measles.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox.....	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions.....	<input type="checkbox"/>	<input type="checkbox"/>	Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Any Other Condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____		
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hepatitis-Type.....	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to The Foot & Ankle Centre of New Jersey for all insurance benefits otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all service rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

Signature of Responsible _____ Date _____