DR. JORDAN STEINBERG, DPM
Podiatric Medicine & Surgery

Patient Medical History Form

Patient Name: _____

Podiatric History

What is the **chief complaint** for which you have come to be treated? (Include foot, toes, ankle, knees, and hip complaints.)

_____

_____

_____

Have you ever been **under the care of a Podiatrist before**?

☐ Yes ☐ No

If Yes,
Name _____

Last Visit _____

Please indicate if you **now have** or **have had problems** with any of these by marking an "**X**".

___ Ankle pain
___ Athlete's foot
___ Bunions
___ Corns and calluses
___ Cramps in feet or legs
___ Flat feet
___ Heel pain
___ Ingrown toenails
___ Injuries to the foot
___ Plantar warts
___ Swelling in ankles or feet
___ Tired feet

Your **shoe size** _____

Athletic activities in which you participate (please list and indicate frequency):

_____

_____

List **surgeries**, **serious injuries,** and **serious illnesses:**

_____

_____

_____

_____

_____

Allergies and Medications

Allergies and Drug Intolerance

☐ No known drug allergies

☐ Adhesive/Tape
☐ Aspirin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local anesthetics (e.g., Novocaine)
☐ Penicillin
☐ Seafood
☐ Sulfa
☐ _____

Medications you are taking (prescription, non-prescription, herbal supplements, vitamins, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please go to the next page.

Form version 2016.01.01

DR. JORDAN STEINBERG, DPM
Podiatric Medicine & Surgery

Patient Medical History Form

General Medical History

Your **occupation** _____

Your **height** _____

Your **weight** _____

Do you **smoke**?
☐ Yes ☐ No

Have you **ever smoked**?
☐ Yes ☐ No
How much? _____ packs / _____
Years smoked _____

Drink **alcohol**?
☐ Yes ☐ No
How much? _____

Recreational drugs?
☐ Yes ☐ No
What? _____

Pregnant or possibly pregnant?
☐ Yes ☐ No

Please indicate if **you** or a **family member now have or have had** any of the following by marking an "**X**".

	You	**Family Member**
___	Anemia	
___	Arthritis	___
	Type: _____	
___	Artificial heart valves	
___	Artificial joints	
___	Asthma	___
___	Back problems	
___	Bleed easily	___
___	Cancer	___
___	Chemical dependency	___
___	Chest pain	___
___	Circulatory problems	___
___	Diabetes	___
___	Deep vein thromboses	___
___	Epilepsy	___
___	Fibromyalgia	
___	Gout	
___	Heart disease	___

Please indicate if **you** or a **family member now have or have had** any of the following by marking an "**X**".

	You	**Family Member**
___	Heartburn, chronic	___
___	Hemophilia	___
___	Hepatitis	
___	High blood pressure	___
___	HIV/AIDS	
___	Kidney problems	___
___	Liver disease	___
___	Lung/respiratory disease	___
___	Mental illness	___
___	Phlebitis	___
___	Psoriasis	___
___	Rheumatic fever	
___	Stroke	___
___	Thyroid problem	
___	Tuberculosis	
___	Ulcers, stomach	
___	Varicose veins	
___	Venereal disease	

I certify that the above information is correct to the best of my knowledge. I give my permission to the attending physician(s) to administer and perform such procedures as may be deemed necessary for my diagnosis and treatment.

_____ Date

_____ Signature of Responsible Party

_____ Relationship, if not Patient

_____ Printed Name of Responsible Party

Form version 2016.01.01

FLORHAM PARK PODIATRY
DR. JORDAN STEINBERG, DPM

PATIENT INFORMATION				❑ ***New Patient*** ❑ ***Established PT***
Patient's FIRST Name: MIDDLE: LAST:				Social Security #:
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed	Employer Name:
Your Address:		City	State:	Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other		Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline	Language: ❑English ❑Spanish ❑Other:_____	
Primary Phone#: ❑ Cell ❑ Work ❑Home ( )		Alternate Phone#: ❑ Cell ❑ Work ❑Home ( )	Email Address: Appointment reminder by email? ❑ Yes ❑ No	
Referring Physician Name:		How did you hear about our office?		
Primary Physician Name:		Reason for visit:	Date of Injury/Onset:	

RESPONSIBLE PARTY:		
Person Financially Responsible [Guarantor] ❑ Self Only→Skip to insurance section ❑ Other Guarantor→Complete this section	Guarantor's Full Name:	Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Birth date: / /	Social Security #:

INSURANCE INFORMATION:			
Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ WC ❑ Lien	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
COPAY: $	Annual Deductible: $ ❑ Met ❑ Not Met ❑ Don't Know	Coinsurance: ❑ None (Plan pays 100%) ❑ 80/20 ❑ 90/10 ❑ 70/10 ❑ Don't Know	Effective Date: / /
Is plan thru employer? ❑ No ❑ Yes	Employer address:		Occupation:
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other:	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to Dr. Jordan Steinberg D.P.M. as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: _____ Date _____

COMMUNICATION PREFERENCES:

I understand that the staff and/or physician(s) at Florham Park Podiatry may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Language_____Preferred method for communication: (Home) (Work) (Cell) (Email)

Can we leave a message on machine or with whoever answers? (Circle: Yes or No)

CONSENT TO DISCUSS HEALTH CARE INFORMATION:

I AUTHORIZE THE STAFF AND /OR PHYSICIAN(S) AT FLORHAM PARK PODIATRY TO DISCUSS MY HEALTH CARE INFORMATION WITH THE INDIVIDUALS LISTED BELOW. I UNDERSTAND THAT I AM NOT REQUIRED TO LIST ANYONE. I ALSO UNDERSTAND THAT I MAY CHANGE THE LIST IN WRITING AT ANYTIME.

NAME_____ RELATIONSHIP_____ PHONE#_____

NAME_____ RELATIONSHIP_____ PHONE#_____

AUTHORIZATION TO ACCESS ELECTRONIC PRESCRIPTION RECORDS: I authorize Florham Park Podiatry to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff , and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Florham Park Podiatry medical record. My signature Below certifies that I authorize the access to my prescription records.

PHOTOGRAPH RELEASE FOR MEDICAL RECORDS: (YES) (NO)

I hereby authorize and consent to the taking of photographs and moving pictures of me by Florham Park Podiatry, its agents or employees. I hereby authorize and consent to the use of such photographs and moving pictures for identification purposes in my medical record.

I hereby release Florham Park Podiatry, its medical staff, agents, and employees from all liability related to the making and use of such photographs and moving pictures for the purpose as stated above.

RELEASE AND ASSIGNMENT OF BENEFITS: I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the provider of Florham Park Podiatry for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/ or not covered by my health insurance plan. I authorize Dr. Jordan Steinberg D.P.M. LLC or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

CONSENT TO TREAT: I the undersigned, voluntarily consent to and authorize Florham Park Podiatry through its physician(s), employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of Dr. Jordan Steinberg D.P.M. LLC physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

ACKNOWLEDGEMENTS AND AGREEMENT:

- I acknowledge receipt of Florham Park Podiatry Financial Policy, and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices, and agree to all the terms and conditions contained therein (unless I have opted out alone).
- I agree to allow access to my electronic prescription records as described above.
- I acknowledge receipt of the Florham park Podiatry Electronic Mail (Email) Policy, and agree to all the terms and conditions contained therein.
- I agree to the release and assignment of benefits as described above.
- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

Patient/Representative's Signature_____

Date_____

IF YOU ARE UNDER 18 YEARS OF AGE WE WILL NEED A PARENT SIGNATURE.

IF SIGNED BY AUTHORIZED REPRESENTATIVE, PRINT NAME_____

RELATIONSHIP TO PATIENT/AUTHORITY TO SIGN_____

Please present primary and secondary insurance card(s) so we may make a copy, along with your driver's license or valid photo identification. If you do not have your card, you will be responsible for services rendered at that time, due to the overwhelming addresses for each insurance company and the necessity of having your ID #. If a referral is needed, it will need to be supplied at the time of the visit. Please take note this office will only submit to two insurances. If this is workers compensation , auto claim, or claims going to your lawyer, please supply that information on date of service. Please take note you will ultimately be responsible for bill.

Please be aware it is your responsibility to be aware if your insurance does not cover benefits for podiatry services or a particular service or treatment (diagnosis/billing code), under your plan. We strongly suggest that you call your insurance so that you understand your benefits and coverage, and the insurance's disclaimer that they DO NOT GUARANTEE PAYMENT, not even with an authorization.

Some insurances are just administrators and actual coverage or if we are in network may be different. So please call your insurance on back of card under member services to verify if we are on your plan and what your benefits/coverage includes for services, treatments, and durable medical equipment if necessary. When you call insurance, please make note with whom you spoke and reference #, as we do, in case needed for appeals. But please be aware we will do all that is required for appeal on our behalf, but you may have to call and send written documentation to your insurance as well. If appeal is unsuccessful, you are ultimately responsible for any services or products.

Please follow up with your insurance on any Coordination of Benefits (COB) so your claim is not denied in which you will receive a bill.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM(S) AND HEREBY ASSIGN DR. JORDAN STEINBERG D.P.M. LLC, ALL PAYMENTS FOR MEDICAL SERVICEs RENDERED TO SELF OR DEPENDENTS.

I ACKNOWLEGE THAT I AM RESPONSIBLE FOR ALL OF THE CHARGES AND/OR PRODUCTS RENDERED TO ME OR ANY MEMBER OF MY FAMILY.

Dr. Jordan Steinberg D.P.M. LLC
Financial Policy
Effective: February 8, 2016

Patient Name:_____ (please print name)

Thank you for choosing Dr. Jordan Steinberg D.P.M. LLC as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that Dr. Jordan Steinberg D.P.M. LLC will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Dr. Jordan Steinberg D.P.M. LLC. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Dr. Jordan Steinberg D.P.M. LLC at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen.

5.

6. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

7. _____ Dr. Jordan Steinberg D.P.M. LLC will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Dr. Jordan Steinberg D.P.M. LLC if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ Date:_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Dr. Jordan Steinberg D.P.M. LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ Date:_____