WELCOME TO OUR OFFICE
UNIVERSITY FOOT & ANKLE CENTER, LLC
Mark J. Berger, D.P.M.
Genine M. Befumo, D.P.M.
Diplomates American Board Podiatric Surgery

Patient Name: ______________ ______________ ____ Date of Birth: ____/____/____ Age: ____ Sex: M F
Last First MI

Home Address: ______________________________ City/State: ______________ Zip: ________

Social Security #: ______ - ____ - ______

MAY WE LEAVE A MESSAGE?

Home Phone #:	(____) ____ - ______	YES	NO
Cell Phone #:	(____) ____ - ______	YES	NO
Work Phone #:	(____) ____ - ______	YES	NO

E-mail Address: ____

I have received and understand the HIPPA Information ______________________________
Signature

Emergency Contact: ______________________ Relationship: ____________ Phone # (___) ____ - ______

Primary Care Doctor ____________________ City/State: ______________ Phone # (____) _____ - _______

How were you referred to this office? ____

INSURANCE INFORMATION

Primary Insurance Company Name: ____

Secondary Insurance Company Name: ____

Responsible Party Insured Name: ____________________________ Date of Birth: ____/____/____

Social Security # of Insured Party: ____-____-______ Insurance ID # ______________________________

ASSIGNMENT OF INSURANCE BENEFITS

The hereby authorize this office to release any and all information necessary to secure reimbursement from any insurance company in which I have subscribed. I hereby authorize and direct payment to University Foot & Ankle Center for the medical and/or surgical benefits, if any, otherwise payable to me under the terms of my insurance. I have read and understand the above and agree to comply.

Signature ____ Date: ________________

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MEDICAL HISTORY
Dr. Berger/Dr. Befumo

Have you ever had any of the following?

Condition			Condition			Condition		
Acid Reflux	Yes	No	Fibromyalgia	Yes	No	Neuropathy	Yes	No
Anemia	Yes	No	Gout	Yes	No	Open Sores	Yes	No
Arthritis	Yes	No	Heart Attack	Yes	No	Parkinson's	Yes	No
Asthma	Yes	No	Heart Disease/Failure	Yes	No	Pneumonia	Yes	No
Back Trouble	Yes	No	Hepatitis	Yes	No	Rheumatic Fever	Yes	No
Bladder Infections	Yes	No	HIV+/AIDS	Yes	No	Sickle Cell Disease	Yes	No
Abnormal Bleeding	Yes	No	High Blood Pressure	Yes	No	Skin Disorder	Yes	No
Blood Clots	Yes	No	Kidney Disease	Yes	No	Sleep Apnea	Yes	No
Blood Transfusion	Yes	No	Liver Disease	Yes	No	Stomach Ulcers	Yes	No
Bronchitis/Emphysema	Yes	No	Low Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Migraine Headaches	Yes	No	Thyroid Disease	Yes	No
Diabetes #Yrs___	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No

Other Conditions: ______________________________

Allergies: ___Foods ___Aspirin ___Codeine ___Penicillin ___Sulfa Drugs ___Iodine
___Tape ___Local Anesthesia ___Novocain ___Seasonal Other: ______________

Race: ___American Indian ___Asian ___Black/African American ___Hispanic ___White
Primary Language: ______________ Ethnicity: ______________

SOCIAL HISTORY

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

Employer: ______________ Occupation: ______________

Exercise: ___Never ___Rare ___Occasional ___Weekly ___Several x Wk ___Daily
Types of exercise: ______________________________

Use of Alcohol: ___Never ___No Longer Use ___History of Alcohol Abuse ___Socially
Use of Tobacco: ___Never ___Quit- How long ago?___ ___Smoke ___Packs/Day
Use of Recreational Drugs: ___Never ___Quit-How long ago? ___ Type______________

FAMILY HISTORY:

	Mother	Father	Brother	Sister	Other
Arthritis					
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Stroke					
Thyroid					
Other:					

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REVIEW OF SYSTEMS:

Please circle if you have now or have ever suffered from the following:

Constitutional: Fevers / Chills / Sweats / Loss of Appetite / Fatigue / Nausea / Vomiting / Weight Loss (unintentional)____________________

EENT: Blurred or Double Vision / Eye Pain or Irritation / Eye Discharge / Failing Vision / Cataracts / Sensitivity to Light / Earaches / Ears Ringing / Decreased Hearing / Difficulty Swallowing / Frequent Nose Bleeds / Frequent Sore Throat / Prolonged Hoarseness / Sinus Trouble or Congestion____________________

Cardiovascular: Chest Pain / Fainting Spells / Heart Palpitation (fast, irregular heart) / Shortness of Breath / Ankle Swelling

____

Respiratory: Chronic Cough / Shortness of Breath / Chronic Wheezing / Coughing Up Blood / Excessive Phlegm

____

Gastrointestinal: Persistent Nausea / Vomiting / Diarrhea / Constipation /Change in Appearance of Stool / Chronic Abdominal Pain / Bloody or Very Black Stool / Jaundice (yellow skin)

____

Urological: Painful Urination / Blood in Urine / Increased Frequency of Urination / Unusual Vaginal Discharge ____________________

Musculoskeletal: Back Pain / Joint Pain / Joint Swelling / Muscle Cramping / Muscle Weakness / Muscle Stiffness / Arthritis

____

Skin: Skin Rashes / Itching / Chronic Dry Skin / Suspicious moles or other skin abnormalities you are concerned about____________________

Neurologic: Headache / Unable to Move parts of your Body at Times / Weakness / Numbness / Tingling Sensations / Seizures / Fainting Spells / Tremor, Hands Shaking / Dizziness

____

Endocrine: Excessive Appetite / Cold Intolerance / Heat Intolerance / Excessive Thirst and Urination / Significant Weight change

____

Lymphatic: Excessive Bruising / Excessive Bleeding / Swollen Glands (in Neck, Armpits, or Groin)

____

Vascular: Leg or Calf Pain / Night Cramps / Rest Pain / Swelling / Bleeding or Clotting Disorders / Easy Bruising ____________________

Prior Surgeries: ACL Reconstruction / Amputation of Toe / Artificial Joint Replacement / Foot Surgery / Kidney Surgery / Stent Insertion / Vascular Surgery /____________________

Patient's Signature: ____________________ **Date:** __________

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CURRENT COMPLAINT:

Shoe Size: _____
Height: _______
Weight: _______

What specific problem brings you to our office today? ______________________________

Have you ever seen a podiatrist before? Yes No Date of Last Visit: ___/___/_____

How long ago did this problem start? ____________ Days/ Weeks / Months / Years

Did your pain/problem: ____Begin all of a sudden ____Gradually develop over time

How would you describe your pain? ___No Pain ___Sharp ___Dull ___Aching ___Burning ___Radiating ___Itching ___Stabbing ___other ______________________________

How would you rate your pain on a scale from 0 to 10? (Please Circle)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since pain or problem began, has it: ___Stayed The Same ___Become Worse ___Improved

What makes your pain or problem feel worse? ___Walking ___Standing ___Daily Activities ___Resting ___Dress Shoes ___High Heels ___Flat Shoes ___Any Closed Toe Shoe ___Running ___Other ______________________________

What makes your pain or problem feel better? ______________________________

What treatments have you had for this problem? ______________________________

How has this problem affected your lifestyle or ability to work? ______________________________

Was this problem caused by an injury? ___Yes (Describe) ______________________ ___No
If Yes, was it a work-related injury? ___Yes ___No

____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

______________________________ ______________________
Signature **Date**

______________________________ ______________________
If other than Patient, Relationship to Patient Date

……please complete next page

Patient Name:______________________________ Date of Birth ____/____/______

Please list all medications you are currently taking (Including Prescriptions, Over-the-Counter Meds and Herbal Supplements):

Name of Medication	Dose	Reason

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UNIVERSITY FOOT & ANKLE CENTER
G-12 Brier Hill Court ~ East Brunswick, NJ 08816 ~ Telephone: (732) 432-7250
Mark J. Berger, D.P.M., F.A.C.F.A.S. Genine M. Befumo, D.P.M., F.A.C.F.A.S.

THE FINANCIAL OFFICE POLICIES AS OF JANUARY 2016

Commercial/Indemnity Subscribers:

For Office Services:
Payment is expected as services are rendered unless prior financial arrangements have been made. A receipt will be provided for you which can also be used for submission to any secondary insurance or health care accounts you may have.

For Surgical Services:
Our office will submit surgical fees to your health insurance carrier.

HMO & PPO Patients:
It is ***impossible*** for the staff to know everything about your health insurance coverage; they are often tailored to suit the needs of the employer. Please read the information booklet provided to you by your health insurance carrier.

In order to submit charges for services rendered, you will need to provide a referral from your primary physician, if required, copies of your health insurance and identification cards. A copay is required for each visit.

Medicare & Medicare HMO Patients:
We are participating providers for Medicare, therefore you are responsible only for deductibles and the 20% co-insurance. If your primary or secondary health insurance carrier is an HMO, you will need to provide referrals from your primary physician. We will need copies of your health insurance identification cards.

Cancellation Policy:
As a courtesy and in order to accommodate all our patients, we ask that you give 24 hour notice for cancellation or rescheduling of an appointment.

A **$25 fee** will be charged for failure to comply with this request for regularly scheduled appointments. A **$50 fee** will be charged for an orthotic casting that is missed.

Durable Medical Equipment:
Please be advised that insurance companies have been giving out misinformation regarding ***all*** durable medical equipment including the following: Orthotics, which includes all inserts custom made or prefabricated, all splints, braces, etc.

Please assume that unless you have a written document from your insurance company, you are financially responsible for the device.

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Although our office may file Insurance forms, you understand that it is your responsibility to ensure that you are covered for the services rendered. If your insurance company does not pay such bills, for any reason, you understand and agree that you are liable for payment in full.

Any bill not paid within thirty (30) days after it is sent, shall be charged an administrative fee of $5 per month on the outstanding balance until paid or financial arrangements are made. In the event it becomes necessary for us to send the claim to collections, there will be an additional administrative charge of $50.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You realize that non covered services will be billed directly to you as well as deductibles, co-insurance amounts.
3. You attest to the accuracy and completeness of the medical insurance coverage information given.
4. You authorize this office to release medical information necessary to process your claims and appeals.
5. You authorize payment of medical benefits to our office.

Methods of Payment:

***Cash** ***Checks** ***Charge**

Returned check fee is $35.00.

______________________________________ ______________________

Signature of Patient or Responsible Party Date

____

Print Name of Patient of Responsible Party