CONFIDENTIAL

lew	Patient

 \square N

EAST BRUNSWICK FOOT AND ANKLE CENTER REGISTRATION INFORMATION PLEASE PRINT		 Existing Patient Existing Patient: Revise all information that has changed since your last visit 			
DATE/ EMAIL ADDRESS		HOME PHONE: (_)		
		CELL PHONE: (_)		
PATIENT'S NAME:					
LAST		FIRST		МІ	
STREET ADDRESS:					
CITY: STATE:	ZIP:				
SSN: GENDER (check one): MARITAL STATUS (check one): SINGLE MARRIED SE	EPARATED 🗆 DIVOR	CED WIDOWED			
How did you hear about us?					
Patient Employed By:					
Business Address:					
Occupation:		Business Phone: (_)		
Name of Spouse/Responsible Party (If Patient is minor):	LAST	, FIRST			
Spouse/Responsible Party Employed By:					
Business Address:					
Occupation:			1		
RESPONSIBLE PARTY/SPOUSE SSN:					
DO YOU HAVE MEDICAL INSURANCE? NO YES	If Yes:				
NAME OF PRIMARY INS.:	ID#:	GRP #:			
*SUBSCRIBER'S NAME:					
ADDRESS OF PRI. INS.:					
NAME OF SEC. INS.:	ID#:	GRP #:			
*SUBSCRIBER'S NAME:					
*Required by HIPAA					
☐ Pay my balance at time of service ☐ Pay my balance upon receipt	t of first statement \square N	lake payment arrangement pri	or to rende	ering of service	
In case of emergency, who should be notified?		Relationship			
Person authorized to receive PHI		Relationship			
I, the undersigned, hereby authorize the release of any information relating expressly agree and acknowledge that my signature on this document authorize to be rendered, without obtaining my signature on each and every claim to as though the undersigned here.	thorizes my physician to sub to be submitted for myself a nad personally signed the p	submitted on behalf of myself and omit claims for benefits, for service and/or dependents, and that I will l articular claim.	es rendered o be bound by	or for services this signature	
(NAME OF INSURED)	nereby authorize	(NAME OF INSURANCE COMPA	ANY)		
to pay and hereby assign directly to			0		
(AUTHORIZED SIGNATURE OF SUBSCRIBER)			ATE)		

Arnold A. Horowitz, D.P.M.
Podiatric Medicine & Surgery
House Calls Available

www.EastBrunswickFootAnkleCenter.com

HISTORY OF INJURY/FOOT PROBLEM:				
Did the problem result from a specific injury? YES Injury/Accident Date://				
Did your problem begin following: Working Injury Motor Vehicle Accident Daily Regimen Nothing				
Where is your pain located? □ Toe □ Heel □ Ankle □ Ball of Foot □ Arch □ Leg □ Knee □ Back □ Hip				
□ Left □ Right □ Both □ Central □ Inside □ Outside □ Under □ Top				
Other:				
What is your complaint?				
How long have you had this problem and/or condition?				
Please rate your pain on a scale of 1 to 10 (10 being the most painful):				
At rest: 1 2 3 4 5 6 7 8 9 10 At its Worst: 1 2 3 4 5 6 7 8 9 10				
Is the Pain: □ Constant □ Occasional □ Sharp □ Dull □ Aching □ Stabbing □ Throbbing □ Traveling				
Other:				
What symptoms are you experiencing?				
□ Looking □ Numbness □ Giving Away □ Popping □ Tingling □ Grinding □ Swelling □ Bruising				
Other:				
Does anything make your symptoms feel better?				
Does anything make your symptoms feel worse?				
Have you seen another Physician for this problem? YES NO If "Yes": Name of Doctor:				
What treatments have you tried? Nothing Physical Therapy Injections Bracing Icing Compression Medications				
Other:				
Have you had any of the following tests/studies?				
Tests Date (Month/Year) Facility?				
X-Rays				
MRI Scan				
Nerve Studies				
Blood Tests				
Other				
Recreational Activities/Exercise Program: Practitioner's Initials/Date:				

 1 Racetrack Road
 Office: 732-613-TOES (8637)

 Suite B101
 Fax: 732-613-8638

East Brunswick, NJ 08816

Arnold A. Horowitz, D.P.M.
Podiatric Medicine & Surgery
House Calls Available

www.EastBrunswickFootAnkleCenter.com

PAST	MEDICAL HISTORY:					
Chec	k if you currently suffer or ha	ve previously suffered fro	m: 🗆 <i>None</i>			
	High Blood Pressure	Osteoporosis			Are You Allergic?	
	Diabetes	Kidney Disease/Pro	blem		Iodine/Betadine	
	Liver Diabetes	Seizures			Shellfish	
	Heart Disease or Attack	Arthritis			Penicillin	
	Stroke	Thyroid (Hyper/Hy	20)		Sulfa Drug	
	Cancer	Parkinson's Disease			Levaquin	
	High Cholesterol	Psoriasis			Cipro	
	Ulcer Disease (GI)	Multiple Sclerosis			Latex	
	HIV	Rheumatic Fever			Steroids	
	Reflux Disease (GERD)	Gout			Motrin/Advil/Bup	
	Asthma	Depression			Aspirin	
	Hepatitis	Lung Disease			Таре	
	HIV+	Environmental Hazar	ds		Eggs	
MED	s, please list: ICATIONS: (Please complete cocated in EMR and reviewed v		ation list so that	we may make	а сору)	
	Medications	Do	sage		Frequency	
FAM	LY HISTORY: Please check all	that apply:				
	Diabetes		High	High Blood Pressure		
	Blood Clots		Rhei	Rheumatoid Arthritis		
	Cancer		Hear	Heart Disease		
Osteoporosis		Stro	Stroke/Seizures			
Pleas	e describe any immediate far	mily history medical prob	lem:			
SIGN	ATURE:		TODAY'S DA	ATE:		

Suite B101 East Brunswick, NJ 08816

1 Racetrack Road

Office: 732-613-TOES (8637) Fax: 732-613-8638

Arnold A. Horowitz, D.P.M. Podiatric Medicine & Surgery House Calls Available www.EastBrunswickFootAnkleCenter.com

Acknowledgement of Receipt Of **Notice of Privacy Practices**

I acknowledge that I was provided a copy of the Notice o Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

	Date:	
Patient Name (Please Print)		
Parent or Authorized Representative (if applicable)		
Signature		

Office: 732-613-TOES (8637)

Fax: 732-613-8638

Arnold A. Horowitz, D.P.M.
Podiatric Medicine & Surgery
House Calls Available

www.EastBrunswickFootAnkleCenter.com

FOOT AND ANKLE CENTER

SUMMARY OF NOTICE OF PRIVACY PRACTICES

A detailed Notice of Privacy Practices is available upon request.

The following summary outlines how our office will protect your health information, your rights as a patient and our common practices in dealing with your health information.

Uses and Disclosures of Health Information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization: Except as stated in more detail in the Notice of Privacy Practices. We will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization: In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care:
- For certain limited research purposes:
- For purpose of public health and safety:
- To Government agencies for purpose of their audits, investigations and other oversight activities:

- To government authorities to prevent child abuse or domestic violence:
- To the FDA to report product defects or incidents:
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders:
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights: As our patient, you have the following rights:

- To have access to and/or a copy of your health information:
- To receive an accounting of certain disclosures we have made of your health information:
- To request restrictions as to how your health information is used or disclosed:
- To request that we communicate with you in confidence:
- To request that we amend your health information:
- To receive notice of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please submit your concern in writing to:

1 Racetrack Road Office: 732-613-TOES (8637)
Suite B101 Fax: 732-613-8638

East Brunswick, NJ 08816