

Robert W. Hutchison, DPM, FACFAS
 Podiatric Medicine and Surgery
 FootSurgeryNJ.com
 908.688.9100 • FAX: 908.688.9101
 info@FootSurgeryNJ.com
 www.FootSurgeryNJ.com
 1050 Galloping Hill Road - Suite 102
 Union, New Jersey 07083



**American College of
 Foot and Ankle Surgeons™**
Proven leaders. Lifelong learners. Changing lives.



Patient Intake Form

Today's Date: *(Fecha)* _____

Reason for visit: _____ Referred by: _____
(Razon de la visita) *(Referido por)*

PLEASE PRINT

PATIENT'S NAME (last, first) <i>(Nombre de el paciente)</i>									
ADDRESS, CITY, STATE, ZIP <i>(Direccion, Ciudad, Estado,Codigo postal)</i>									
AGE <i>(Edad)</i>	DATE OF BIRTH <i>(Fecha de nacimiento)</i>	SEX <i>(Sexo)</i>		MARITAL STATUS <i>(Estado Civil)</i>				SOCIAL SECURITY # <i>(Numero de Seguro Social)</i>	
		M	F	S	M	W	D	SEP	
				(C)	(V)				
HOME PHONE #: <i>(Numero de telefono)</i>			CELLULAR PHONE #: <i>(Celular)</i>			WORK PHONE & EXT. APPLICABLE <i>(Trabajo)</i>			
Employer's Name <i>(Nombre de su empleado)</i>					Address & Title <i>(Direccion)</i>				
In case of an emergency contact: <i>(Contacto de emergencia)</i>					Telephone No. <i>(Numero de telefono)</i>			Relationship <i>(Relacion)</i>	

INSURANCE INFORMATION: (Informacion de Seguro)

Is your injury a result of an accident? <i>(Es su herida resultado de un accidente?)</i> Date of accident: <i>(Fecha de accidente)</i> _____	NO YES	If yes, please circle what type of accident you had: <i>(Que tipo de accidente?)</i> Motor vehicle Worker's comp. Slip & fall <i>(Accidente de carro)</i> <i>(Accidente de trabajo)</i> <i>(Caida)</i>
Primary Insurance Carrier: <i>(Seguro primario)</i>		Telephone No.: <i>(Numero de telefono)</i>
I.D. / Claim No. <i>(Number de identificacion)</i>		Adjuster / Case Manager: <i>(Nombre de la persona encargada de su caso)</i>
Secondary Insurance Carrier: <i>(Seguro secundario)</i>		Telephone No.: <i>(Numero de telefono)</i>
I.D. / Claim No. <i>(Number de identificacion)</i>		Group No.:
Tertiary Insurance Carrier:		Telephone No.:
I.D. / Claim No.		Group No.:
If you are being represented by an attorney, please supply us with their complete information: <i>(Si esta siendo representado por un abogado, porfavor escriba la informacion aqui)</i>		
Name: _____ Telephone No.: _____ Address, City, State & Zip: _____		

PAGE 2: PLEASE PRINT ALL INFORMATION

Height: _____
(Estatura)

Weight: _____
(Peso)

Do you smoke? NO YES (how much?) _____
(Usted fuma?) (Cuanto)

Do you consume alcohol? NO YES (how often?) _____
(Consumo alcohol?) (Frecuencia)



MEDICAL HISTORY

Please place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------------------|--|-----------------------|--|--------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Ear Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No
If yes, please explain _____



MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? Yes No



ALLERGIES

- | | |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfis |
| <input type="checkbox"/> Iodine | |
| Other _____ | |

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Relationship to Patient _____

CONSENTS:

Patient name: _____ Date: _____

ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize Ambulatory Surgical Center of Union County and Robert W. Hutchison, DPM, LLC to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependent, to the physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to Ambulatory Surgical Center of Union County and Robert W. Hutchison, DPM, LLC to pursue any medical bills, relating to treatment or care by this office in addition to the above.

X _____
Patient signature

NO FAULT AND/OR WORKER'S COMPENSATION PATIENTS

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney _____.

I further authorize Ambulatory Surgical Center of Union County and Robert W. Hutchison, DPM, LLC to pursue payment of my bills. I understand that all medical bills will be submitted to the responsible insurance carrier and will *only* be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, which I am responsible for. I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependent and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed will arbitrate my bills for payment.

X _____
Patient signature

HIPPA PRIVACY ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy Ambulatory Surgical Center of Union County and Robert W. Hutchison, DPM, LLC privacy notice.

This notice is effective as of today's date.

X _____
Patient Signature

PHOTOGRAPH CONSENT

I, _____, authorize my picture be taken. I understand that my photograph will be attached to my medical chart and only used for identification purposes. I understand & do not authorize my image be used for any other purpose.

X _____
Patient Signature

() *Declined - You may opt not have your photograph taken but must supply us with picture identification for our records.*

Robert W. Hutchison, DPM, FACFAS - Ambulatory Surgical Center of Union County
1050 Galloping Hill Road • Suite 102 - Union, New Jersey 07083

Disclosure of Ownership

To Our Patients:

"Public law of the State of New Jersey mandates that a physician, chiropractor or podiatrist inform his patients of any significant financial interest he may have in a health care service."

Accordingly, we wish to inform you that the following doctors have a financial interest in the Ambulatory Surgical Center of Union County, LLC.

Clifford Botwin, D.O. Gregory Charko, M.D. Glenn Davison, D.P.M.

Douglas DeLorenzo, D.P.M. Muhammad Feteiha, M.D. James Frost, M.D.

David Greifinger M.D., Robert Hutchinson, D.P.M. Arnaldo Jimenez, M.D.

Warren Kaplan, D.P.M. Stanley Klein, D.P.M. Ronald Pallant, M.D.

Thomas Ragukonis, M.D. Mark Schoenfeld, M.D. Todd Stevens, D.P.M.

These physicians have become owners as a result of their commitment to quality health care and to provide better service to their patients. The Ambulatory Surgical Center of Union County, LLC. is fully accredited by the Center for Medicare and Medicaid Services (CMS).

The patient has been informed whether any of the services or facility fees associated with the referral will be considered to be, and reimbursed at, an "out-of-network" level by the patient's insurance carrier or other third party payer.

You may, of course seek treatment at a health care service of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

I have read the above and understand.

Patient Signature

Date