

Welcome to our Office

Patient Information Sheet

Dr Steven Marder

Please fill out this form **COMPLETELY**, write N/A where applicable and sign it. Thank you.

Social Security#		Primary Care Physician:	
First Name:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Middle Initial:		Do you have Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last Name:		Relationship to Policy Holder	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Street Address:		Marital Status:	<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
City, State, Zip		Spouse's Name:	
Date of Birth:	Age:	Spouse's Date of Birth:	
Email:		Spouse's Social Security#	
Home Phone:	()	Emergency Contact:	
Work Phone:	()	Emergency Telephone #	
Cell Phone:	()	Employer Name:	
Reason for today's Visit:		Who referred you to our office:	

Patient's Insurance Information

Primary Insurance Company Information:	Secondary Insurance Company Information:
Company Name: _____	Company Name: _____
Address: _____	Address: _____
Insurance# _____	Insurance# _____
Group# _____	Group# _____
Effective Date: _____	Effective Date: _____
Do you have a Co-pay? <input type="checkbox"/> Yes Amt \$ _____ or <input type="checkbox"/> NO	Do you have a Co-pay? <input type="checkbox"/> Yes Amt \$ _____ or <input type="checkbox"/> NO

Policy Holder Information	Policy Holder Information
Name: _____	Name: _____
Policy Holders SS# _____ - _____ - _____	Policy Holders SS# _____ - _____ - _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Policy Holders Date of Birth: _____	Policy Holders Date of Birth: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Today's Date: _____ Patient's Signature: _____

Steven J Marder, DPM, FACFAS
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY
BOARD CERTIFIED IN FOOT SURGERY
1049 BROADWAY, WEST LONG BRANCH, NJ 07764 • 732-870-9700

Describe the foot or ankle related problem?

Name of your Doctor _____ Phone _____

How are you currently treating this problem?

If another Doctor is treating this problem; Name _____

Phone _____

Any known allergies? Latex ? Food ? Medication ?

.....

List of Medications

Had any surgery in last 3 years?

Any prior foot surgery? What and When?

Is this visit due to an accident?..... Workmen's Compensation?.....Date of Injury.....

Signature _____ Date _____

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Patient Name: _____ **DOB:** _____

Medical History					
	Yes	No		Yes	No
Chicken pox			Asthma		
Measles			Arthritis		
Mumps			Epilepsy		
Polio			High BP		
Diphtheria			Low BP		
Hepatitis			Heart Disease		
Tuberculosis			Coronary Artery Disease		
Rheumatic Fever			Heart Attack		
Scarlet Fever			Angina Chest Pain		
Thyroid Problems			Shortness of Breath		
Kidney Disease			Stroke		
Urinary Tract Infection			Cancer		
Phlebitis			Diabetes		
Hiatal Hernia			Any Blood Disorders		
Anemia			Sickle Cell Anemia Trait		
Gout			Thrombocytopenia		

Flu Shot this year? _____ **Shoe Size** _____
Patient Height _____ **Patient Weight** _____

Smoker: Yes / No / Quit? How long: _____

Comments: _____

Signature _____ **Date** _____

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GENERAL CONSENT:

I wish to be treated by Dr. Marder. While I am a patient I permit the doctor and all persons caring or me to treat me in ways that are beneficial to me. I understand that no guarantees have been made to me about the outcome of this care. If the services rendered are of a recurring status, my signature shall be valid for care rendered throughout this period. I will notify your office of any visit to another podiatrist. I will also notify your office of any change in address, employment, insurance, etc.

RELEASE OF INFORMATION:

I understand that my medical records are kept in both hard copy and electronic form and that the doctors and employees involved in my care have access to both. I understand that the doctor and employees may seek, release and verify all or part of my medical and/or financial records to any person, corporation or government agency which may be liable under a statute, regulation or contract with this office, the patient, a family member, or employer of the patient for all or part of the doctor's services and/or fees.

ASSIGNMENT OF BENEFITS:

I authorize payment from my primary insurance as well as my secondary insurance, if applicable, directly to Dr. Marder. For health insurance benefits payable for service rendered under the terms of my policy.

MEDICARE-RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize any holder of medical or other information about me to release to the social security administration or its intermediaries or carriers any information needed for a MEDICARE claim. I authorize the office to submit a claim to MEDICARE and request that direct payment of authorized benefits be made on my behalf. I assign benefits payable to Dr. Marder. I understand that the service I receive may not be covered by my MEDICARE insurance. In this event, I will be responsible for all non-covered charges.

FINANCIAL AGREEMENT:

I agree to make prompt payment to Dr. Marder when billed for any and all charges not covered by my insurance. **I understand I am responsible for deductibles, co-payments and/or co-insurance.** I understand that if the doctor does not participate with my insurance plan, **I am responsible for full payment when services are rendered. I realize it is my responsibility to obtain a referral, pre-certification or a second opinion** should it be required **prior to services rendered.** If my insurance carrier or utilization management department deems that medical services' to be given or already given are not medically necessary or a non-covered service, I must pay for those services. I understand it is my responsibility to know my insurance policy's rules and benefits and if I do not comply with the requirements of my insurance plan, I will be fully responsible for all charges. I understand that I may be charged 1 ½% interest monthly for any past due balance.

I have read this form. I understand and agree to its content.

Signature/Authorized Person

Relationship to Patient

Date

Patient Name (Please Print): _____

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Receipt of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the notice.

I authorize Dr Steven Marder or his staff to leave a phone message regarding my appointment for foot health and /or related business on my answer machine (at home or work) or with the person who answers the phone unless I specify other.

Comments _____

Please Print Name _____

Signature _____

Date _____