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.

SS# or MBI#		Primary Care Physician:	
First Name:		**Gender:**	Male Female
Last Name:		**Do you have Insurance?**	Yes No
Street Address:		**Relationship to Policy Holder**	Self Spouse Other
City		**Marital Status:**	M S D W
State and Zip:		**Spouse's Name:**	
Date of Birth:	**AGE**	**Spouse's Date of Birth:**	
Email:		**Spouse's SS# & Email**	
Cell Phone:		**Emergency Contact:**	
Home Phone:		**Emergency Telephone #**	
Employer Name:		**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:**
Insurance Name: _____	Ins. Name: _____
Insurance #: _____	Insurance#: _____
Co-pay: _____	**Co-pay**: _____
Co-Ins: _____	Co-Ins: _____
Deduct: _____	Deduct: _____

Policy Holder Information	**Policy Holder Information**
Name: _____	**Name: _____**
Last 4 SS# _____	**Last 4 SS# _____**
Address: _____	Address: _____
City: _____	City: _____
State: _____ Zip: _____	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: _____

LBC 5.11.20

Steven J Marder DPM, FACFAS
Fellow, American College of Foot Surgeons

Patient Name: _____ DOB: _____

Describe the foot and ankle related problem:-

_____
_____
_____
_____

Primary Doctor_____ City_____ Phone_____

Pharmacy_____ City_____ Phone_____

How are you currently treating this:

_____
_____
_____

Previously treated by: _____DPM/MD Phone:_____

List of Medication and Dosages:

_____
_____
_____
_____
_____
_____

Allergies to: Latex: Yes No
Medications:_____
_____

Food: _____

Any major surgery in the last 3 years? Yes _____ No _____

Any prior foot surgery? Yes_____ No_____

Is this visit due to an accident? Yes/No Workmen's Comp: Yes/No Date of Injury_____

Signature_____ Date_____

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

Patient Name:_____DOB:_____

Medical History					
	Yes	**No**		**Yes**	**No**
Chicken pox			**Asthma**		
Measles			**Arthritis**		
Mumps			**Epilepsy**		
Polio			**High BP**		
Diptheria			**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_____
LBC 11.1.11

Steven J Marder, DPM, FACFAS

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DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY
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1049 BROADWAY, WEST LONG BRANCH, NJ 07740 · 732-870-9700

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 of 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.

ASSIGNEMNT 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):_____

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, Suite 1, West Long Branch, NJ 07764
732-870-9700

Patient Name: _____ Date:_____

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 home, mobile phone or email unless I specify otherwise.

Comments:_____
_____
_____
_____
_____
_____

Signature_____

Initials_____