ROS Completed: _____ INFO IN CHART: _____

INS & LIC UPLOAD: _____ INTAKE UPLOAD: _____

P.A.C.E.
Podiatry & Ankle Center of Excellence

Podiatry & Ankle Center of Excellence | 59 Veronica Ave Suite 204 | Somerset, NJ 08873

Office Phone: (732) 978-2700 | Fax: (732) 658-2590 | www.pace-nj.com

PATIENT REGISTRATION

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ Male | Female AGE _____

MARITAL STATUS O Single O Married O Divorced O Separated O Widowed O Partner O Minor

ADDRESS _____

EMAIL _____

OCCUPATION_____EMPLOYER_____

____Employed ____Full Time Student ____Unemployed ____Self Employed _____Part Time Student _____Retired

CELL # _____HOME # _____WORK # _____

EMERGENCY CONTACT _____RELATIONSHIP _____

PHONE_____ADDRESS _____

PRIMARY INSURANCE INFORMATION:

POLICY HOLDER: _____SELF _____OTHER

IF OTHER, FULL NAME OF POLICY HOLDER: _____

POLICY HOLDER'S PLACE OF EMPLOYMENT: _____

POLICY HOLDER'S DATE OF BIRTH _____/_____/_____ POLICY HOLDER'S PHONE#:_____

RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY_____POLICY/ID #_____

PRIMARY CARE PHYSICIAN: _____ADDRESS: _____

DATE OF LAST VISIT TO PRIMARY CARE PHYSICIAN: _____ PHONE#: _____

PHARMACY NAME: _____ ADDRESS: _____

PHONE #: _____

Who may we thank for referring you to our office? _____

PODIATRY INTAKE

Reason for Visit Today_____

_____

When did your problem begin? Please give an approximate date, if possible: _____

How would you rate the intensity of your pain? (please circle)

0 1 2 3 4 5 6 7 8 9 10

No pain→----------→Unbearable pain

How often is pain present?

- ☐ Constant (80-100%)
- ☐ Occasional (25%-50%)
- ☐ Frequent (50%-80%)
- ☐ Intermittent (comes and goes; 25% or less)

What prior treatments have you received for this problem?

_____

_____

Have you ever been treated by a podiatrist before? Yes: _____ No: _____If yes, what for?

_____

_____

Have you been hospitalized in the past five years? Yes: _____ No: _____If yes, what for?

_____

_____

ALLERGIES: (Please also note any reactions if exposed) _____

_____

CURRENT MEDICATION LIST: (Please include dosage/frequency)

_____

_____

_____

REVIEW OF SYSTEMS

(Check the following symptoms if applicable)

CONSTITUTIONAL	○ Chills ○ Weight Gain	○ Fatigue ○ Weight Loss	○ Fever	○ Weakness
CARDIOVASCULAR	○ Chest Pain ○ Heart Murmur ○ Palpitations	○ Cool Extremities ○ Heart Valve ○ Rheumatic Fever	○ Cramps in Legs/Feet ○ High Blood Pressure ○ Varicose Veins	○ Hair Loss on Legs ○ Leg/Foot Ulcers ○ Vascular Grafts
MUSCULOSKELETAL	○ Ankle Sprain ○ Broken Ankle ○ Corns ○ Childhood Foot Problems ○ In-Toeing ○ Knee Pain ○ Neuroma	○ Arch Pain ○ Broken Foot Bone ○ Flat Feet ○ Gait (Walking) Problems ○ Joint Implants ○ Lower Back Pain ○ Orthotic or Shoe Insert Use	○ Arthritis ○ Bunions ○ Gout ○ Hammer or Mallet Toes ○ Joint Pain ○ Muscle Cramps ○ Paralysis	○ Back Problems ○ Calluses ○ Heel Pain ○ High Arch Feet ○ Joint Stiffness ○ Muscle Stiffness ○ Weakness ○ Toe Walking
DERMATOLOGICAL	○ Athlete's Foot ○ Hives ○ Mole Changes	○ Dryness ○ Ingrown Nails ○ Rash	○ Eczema ○ Itching ○ Scars	○ Fungal Nails ○ Lumps ○ Warts
NEUROLOGICAL	○ Blackouts ○ Neuromas ○ Stroke	○ Burning ○ Numbness ○ Tingling	○ Charcot Neuroarthropathy ○ Tremors	○ Fainting ○ Speech Problems ○ Unsteady Gait (Walking)
ENDOCRINE	○ Fatigue ○ Weight Loss	○ Goiter ○ Weight Gain	○ Thirst	○ Thyroid
HEMATOLOGIC/ LYMPHATIC	○ Anemia ○ Recent Chemotherapy	○ Bleed Easily ○ Slow Healing Clots	○ Blood Clots ○ Swollen Glands	○ Easy Bruisability ○ Transfusion Reaction
ALLERGIC/ IMMUNOLOGIC	○ Hives ○ Sneezing ○ Wheezing	○ Itchy Nose ○ Stuffy Nose	○ Itchy Eyes ○ Swelling	○ Runny Nose ○ Watery Eyes

MEDICAL HISTORY	○ Amputation ○ Anemia ○ BPH ○ Congestive Heart Failure ○ Dementia ○ Epilepsy ○ HIV ○ Myocardial Infarction ○ Stroke	○ Anxiety ○ Back Problem ○ COPD ○ Depression ○ GERD ○ Headache ○ Migraine ○ Tuberculosis	○ Arthritis ○ Breast Cancer ○ Cancer ○ Dermatitis ○ Glaucoma ○ Hepatitis ○ Pneumonia ○ Thyroid Disease	○ Asthma ○ CAD ○ High Cholesterol ○ Diabetes ○ Gout ○ Hypertension ○ Kidney Stone ○ Ulcer (GI)

List any additional medical history:_____

Height: _____ Weight: _____ Shoe size:_____

If you are a diabetic, please complete the following:

HbA1C% (most recent/date): _____ Fasting Blood sugar (most recent/date): _____

Check if applicable

FAMILY HISTORY	O Anemia O Back Problem O COPD O Dermatitis O Glaucoma O Hepatitis O Kidney Problems O Stroke	O Anxiety O Breast Cancer O Dementia O Diabetes O Gout O High Blood Pressure O Migraines O Thyroid Disease	O Arthritis O Cancer O Depression O Epilepsy O Headache O HIV O Pneumonia O Tuberculosis	O Asthma O Congestive Heart Failure O GERD O Heart Attack O Hypercholesterolemia O Prostate Issues O Stomach Ulcers

List any additional ***family*** history: _____

SOCIAL HISTORY

CIGARETTES	**CIGARS**	**PIPES**
Date Last Used _____	Date Last Used _____	Date Last Used _____
Daily Usage _____	Daily Usage _____	Daily Usage _____
Years Smoking _____	Years Smoking _____	Years Smoking _____
Cessation Attempts _____	Cessation Attempts _____	Cessation Attempts _____
Packaging _____	Packaging _____	Packaging _____
BEER	**WINE**	**HARD LIQUOR**
O Social O Occasional O Light O Heavy	O Social O Occasional O Light O Heavy	O Social O Occasional O Light O Heavy

Social Use: < 3 standard drinks during a social, holiday, or special event. **Occasional Use**: ≤ 3 standard drinks per week. **Light Use:** 4-7 standard drinks per week, heavy use is defined as: ≥ 7 standard drinks per week

List any recreational drug use: _____

SURGICAL HISTORY	O AAA Repair O Breast Reduction O Cesarean Section O ESWL O Gastric Banding O Hip Surgery O Knee Surgery O Oophorectomy Unilateral O Prior Surgeries O Shoulder Surgery O Thyroidectomy	O Aortic Aneurysm O CABG O Cholecystectomy O Ectopic Pregnancy O Heart Valve O Hysterectomy O LS Spine Surgery O PTCA O Prostate Biopsy O Sinusectomy (Nasal) O Tonsillectomy	O Appendectomy O Carotid Endarterectomy O Colectomy O Fracture Repair O Hernia Abdominal O Intestinal By-Pass O Lasik O PVD Procedure O Prostatectomy Retro O Splenectomy O Tubal Ligation	O Breast Augmentation O Cataract Extract O Duodenal Ulcer Repair O Gallbladder Surgery O Hip Fracture O Knee Arthroscopy O Mastectomy O Pacemaker O Shoulder Arthroscopy O TURP O Vasectomy

List any additional surgical history: _____

Electronic Communications Consent Form

Patient Name: _____ Date of Birth: _____

You may request that your personal health information be transmitted by alternate means, such as unsecure text messages, email, or third-party health application or software (app); however, we would like you to be aware of the risks involved with sending personal health information in this way. Podiatry & Ankle Center of Excellence, LLC will take appropriate precautions when transmitting elec- tronically to avoid unintentional disclosures, such as verifying your contact information (email address, text number, etc.) for accuracy. If the Practice determines that your request may cause harm to our internal systems, it may be denied. The Practice is not liable for improper disclosure of confidential information that is not caused by our intentional misconduct.

The Risks of Using Electronic Communications

Transmitting patient information electronically can be risky. Please consider the following possibilities before agreeing to communicate with us in this way, or requesting that your health information be transmitted in an unsecure manner. For example, messages and health information can be intercepted, viewed, circulated, altered, forwarded, stored or used without authorization or detection. In addition, electronic communications may be misaddressed, read by employers and online service providers, easily falsified, retained after deletion, used to introduce viruses, or used as evidence in court.

Still Want To Use Electronic Communications?

If you want to use email, texting, etc. to communicate with us, we have some final instructions:

- We cannot guarantee your communications will be read promptly, so please do not use these methods for urgent matters.
- Be sure to follow-up with us by phone if you are expecting a return response from us and do not receive one within 2 business days.
- Please notify us promptly if your contact information has changed.
- Be aware that most electronic communications from patients become a part of their health record.
- Do not use these methods to share sensitive medical information, such as communications about AIDS/HIV or mental health conditions, sexually transmitted diseases or substance abuse.

I understand the risks associated with electronic communications of personal health information, and give my consent for the practice to communicate with me or transmit my health information through the following methods. If I have any questions, I will contact the Practice Privacy Officer.

___ Text Messaging, using this phone number: _____

___ Email, using this email address: _____

___ Other (such as a third-party health app): _____

Patient Signature: _____ *Print Name:* _____

Personal Representative: _____ *Print Name:* _____

Date: _____

HIPAA

Podiatry & Ankle Center of Excellence, LLC

Notice of Privacy Practices

Effective Date: April 14, 2003 | Revised Date: October 27, 2020

Your Information. Your Rights. Our Responsibilities.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. **Ask for an electronic or paper copy of your health record**
- You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

2. **Ask us to correct your health record**
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

3. **Request confidential communications**
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

4. **Ask us to limit what we use or share**
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

5. **Get a list of those with whom we've shared information**
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

6. **Get a copy of this Privacy Notice**
You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

7. **Choose someone to act for you**
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

8. **File a complaint if you feel your rights are violated**
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
- You can file a complaint with the U.S. Dept. of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201; calling 800-368-1019 (TDD: 1-800-537-7697);
  or visiting: hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. **In the situations below, you have both the right and choice to tell us to:**
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

2. **In the situations below, we never share your information unless you give us written permission:**

- Marketing purposes • Sale of your information • Most sharing of psychotherapy notes

3. **In the case of fundraising:**
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

1. **Treat you**
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

2. **Run our organization**
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

3. **Bill for your services**
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

1. **We can share health information about you for certain situations such as:**
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

2. **Do research**
We can use or share your information for health research.

3. **Comply with the law**
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

4. **We can share health information about you with organ procurement organizations.**

5. **We can share health information with a coroner, medical examiner, or funeral director when an individual dies.**

6. **Address workers' compensation, law enforcement, and other government requests**
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

7. **We can share health information about you in response to a subpoena, or in response to a court or administrative order.**

NEW JERSEY PRIVACY AND CONFIDENTIALITY LAW

Except as required by law, we will not share any HIV-related, genetic, mental health, cancer-related or substance abuse information without your written permission.

OUR RESPONSIBILITIES

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

Complaints: If you believe your privacy rights have been violated contact our Privacy Officer at: **Phone: 732 978 2700**

P.A.C.E.
Podiatry & Ankle Center of Excellence

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have been given a copy of Podiatry & Ankle Center of Excellence,LLC's *Notice of Privacy Practices ("Notice"*), which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgment*, or the *Acknowledgment* is not signed for any other reason, state the reason:

_____

_____

Completed by:

_____ _____
Signature of Practice Representative *Date*

_____
Print Name and Title