ADVANCED FOOT AND ANKLE CENTER

92 SOUTH STATE STREET, VINELAND, NJ 08360

DR. JEFFERY KATZ - DR. JOSEPH BISIGNARO - DR. JORDAN KATZ

******FOR STAFF ONLY: Modifications need to saved in WORD and PDF files.******

NAME ___________________________________ ____

FIRST LAST

BIRTHDATE: _______-_______-_______

CIRCLE ONE: (FEMALE) (MALE)

SOCIAL SECURITY NUMBER: __________--__________--___________

STREET ADDRESS 1 ____

STREET ADDRESS 2____

CITY___________________________________STATE__________ ZIP CODE__________________

HOME: _________-_________-__________

WORK: ________-__________-__________

CELL: __________-_________ - __________

**EMAIL (PLEASE PROVIDE) ** ____

ETHNICITY: ☐NON-SPECIFIC ☐HISPANIC LATINO ☐NON-HISPANIC LATINO

PRIMARY LANGUAGE: ☐ENGLISH ☐SPANISH ☐ OTHER

RACE: ☐NON-SPECIFIC ☐ ASIAN ☐BLACK/AFRICAN AMERICAN ☐WHITE

FAMILY DOCTOR:_______________________________________

REFERRING DOCTOR:_____________________________________

WHO REFERRED YOU TO OUR OFFICE:____

EMERGENCY CONTACT: _______________________ PHONE ( ) ________-________________

MESSAGE CAN BE LEFT WITH: ☐PATIENT ONLY ☐PATIENT AND/OR SPOUSE ☐ANYONE ANSWERING PHONE

ADVANCED FOOT AND ANKLE CENTER

92 SOUTH STATE STREET, VINELAND, NJ 08360

DR. JEFFERY KATZ - DR. JOSEPH BISIGNARO - DR. JORDAN KATZ

MARITAL STATUS: DIVORCED (D) MARRIED (M) PARTNER (P) SINGLE(S) WIDOW (W) LEGALLY SEPARATED(X)

SPOUSE NAME:______________________________

STUDENT STATUS: FULL TIME STUDENT (F) NOT A STUDENT (N) PART TIME STUDENT (P)

EMPLOYMENT STATUS: EMPLOYED FULL TIME(1) EMPLOYED PART TIME(2) NOT EMPLOYED(3)

Your employer ____

PHARMACY NAME: ________________ LOCATION:____________________ PHARMACY NUMBER: ______-__________

PRIMARY INSURANCE: ______________________________

I AM THE (SELF) (SPOUSE) (CHILD) (OTHER) TO THE ABOVE INSURANCE POLICY.

POLICY HOLDER NAME:_____________________________________

POLICY HOLDER DATE OF BIRTH______-______-_______ SOCIAL SECURITY: ________-- ______ -- __________
Required for billing

POLICY HOLDER OCCUPATION:____________________________EMPLOYER:_____________________________

SECONDARY INSURANCE: ____________________________

I AM THE (SELF) (SPOUSE) (CHILD) (OTHER) TO THE ABOVE INSURANCE POLICY.

POLICY HOLDER NAME:_____________________________________

POLICY HOLDER DATE OF BIRTH______-______-_______ SOCIAL SECURITY: ________-- ______ -- __________

POLICY HOLDER OCCUPATION:____________________________EMPLOYER:_____________________________

"I request payment of authorized Medicare benefits (and all insurances) to be made on my behalf to this office for services furnished to me. I authorize any holder of medical information about this patient to be released to Health Care Financing Administration or any insurance company or agents to help determine benefits payable for services rendered. I understand and agree that I will be responsible for the payment of services rendered to the above patient."

"I also understand with today's managed care systems of insurance, should my insurance require a referral, I realize that I must bring it in before my treatment and that it is my responsibility to request additional referrals from my Primary Care Physician after I have used up the original referrals or they become expired."

"Additionally, should this office find a need to refer me for tests, or any treatment to another facility, I need to call my insurances company and inquire if they participate and if I need referrals or precert. I acknowledge that I was provided with a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose)and understood the Notice."

"I also understand that if I do not follow the rules of my insurance company, then I will be responsible for my charges. I have provided the office my email address and give permission the office to contact me via email."

"I authorize this office to request medical records from any of my physicians as well as to release any of my medical records to my physicians."

Signature ____ Date ______-______-________

ADVANCED FOOT AND ANKLE CENTER

92 SOUTH STATE STREET, VINELAND, NJ 08360

DR. JEFFERY KATZ - DR. JOSEPH BISIGNARO - DR. JORDAN KATZ

FILL THIS SIDE OUT ONLY IF PATIENT IS COVERED UNDER A PARENT

FATHER'S NAME:___________________ ________________
LAST FIRST

FATHER'S SOCIAL SECURITY NUMBER: _____/_____/_____.

FATHER'S BIRTH DATE: _____/______/______.

FATHER'S OCCUPATION:____.

*****MUST CIRCLE ONE BELOW******
(FULL-TIME) (PART-TIME) (NOT EMPLOYED)
(FULL-TIME STUDENT) (PART-TIME STUDENT)
(SELF-EMPLOYED) (MILITARY SERVICE) (RETIRED)

FATHER'S EMPLOYER:_____________________ WORK PHONE: ______-________-________

MOTHER'S NAME:___________________ ________________
LAST FIRST

MOTHER'S SOCIAL SECURITY NUMBER: _____/_____/_____.

MOTHER'S BIRTH DATE: _____/______/______.

MOTHER'S OCCUPATION:____.

*****MUST CIRCLE ONE BELOW******
(FULL-TIME) (PART-TIME) (NOT EMPLOYED)
(FULL-TIME STUDENT) (PART-TIME STUDENT)
(SELF-EMPLOYED) (MILITARY SERVICE) (RETIRED)

MOTHER'S EMPLOYER:_____________________ WORK PHONE: ______-________-________

ADVANCED FOOT AND ANKLE CENTER

92 SOUTH STATE STREET, VINELAND, NJ 08360

DR. JEFFERY KATZ - DR. JOSEPH BISIGNARO - DR. JORDAN KATZ

MEDICATIONS (list)

☐ **NONE**

medicine	*dosage*

ALLERGIES(list reaction)

☐ **NONE**

☐ aspirin ___________________
☐ cephalosporin______________
☐ codeine__________________
☐ cortisone_________________
☐ erythromycin _____________
☐ ibuprofen_________________
☐ iodine____________________
☐ latex_____________________
☐ novacaine_________________
☐ penicillin_________________
☐ sulfa drugs________________
☐ tape______________________
☐ tetracycline_______________
☐ Tylenol___________________
☐ Other:____________________
☐ Other:____________________
☐ Other:____________________

MEDICAL HISTORY

☐ **NONE**

☐ AIDS/HIV
☐ anemia
☐ aortic aneurysm
☐ arthritis-osteoarthritis
☐ arthritis- rheumatoid
☐ asthma
☐ bleeding tendencies
☐ bronchitis
☐ cancer (type:_____________)
☐ congestive heart failure
☐ Crohn's disease
☐ diabetes
☐ depression
☐ gastric reflux
☐ gout
☐ heart attack
☐ heart valve problems
☐ hepatitis
☐ high blood pressure
☐ irregular heart beat
☐ kidney problems
☐ liver disease
☐ low blood pressure
☐ lupus
☐ mitral valve prolapse
☐ multiple sclerosis
☐ pacemaker
☐ phlebitis
☐ poor circulation
☐ rheumatic fever
☐ seizures
☐ stomach ulcers
☐ thyroid disorder
☐Other:___________________
☐Other:___________________
☐Other:___________________

SURGICAL HISTORY

☐ **NONE**

☐ ankle/foot fracture
☐ back surgery
☐ bowel surgery
☐ brain surgery
☐ carpal tunnel surgery
☐ colon surgery
☐ eye surgery
☐ foot surgery
☐ heart-artery bypass
☐ hip replacement
☐ hysterectomy
☐ knee replacement
☐ organ transplant
☐ thyroidectomy
☐ tubal ligation
☐ vascular surgery
☐ Other: __________________

SOCIAL HISTORY

☐ alcohol use **(non-drinker)**
☐ alcohol use (social drinker)
☐ alcohol use (heavy drinker)
☐ alcohol (recovering alcoholic)

☐ smoking (former smoker)
☐ smoking (heavy smoker)
☐ smoking (light smoker)
☐ smoking **(never smoked)**

FAMILY HISTORY

(circle mom or dad)

☐ **NONE**

☐ cancer- type: __________ mom dad
☐ depression mom dad
☐ diabetes mom dad
☐ gout mom dad
☐ heart disease mom dad
☐ hypertension mom dad
☐ osteoarthritis mom dad
☐ rheumatoid arthritis mom dad
☐ sickle cell anemia mom dad
☐ stroke mom dad
☐ Other: __________________

Name:____________________________________

Today's Date:____-____-______

Signature:_________________________________

ADVANCED FOOT AND ANKLE CENTER

92 SOUTH STATE STREET, VINELAND, NJ 08360

DR. JEFFERY KATZ - DR. JOSEPH BISIGNARO - DR. JORDAN KATZ

REVIEW OF SYSTEMS: (please check off)

CONSTITUTIONAL

☐ **NONE**
☐ anxiety
☐ chills
☐ depression
☐ fever
☐ memory loss
☐ night sweats
☐ panic attacks
☐ weight loss (unintentional)

CARDIOVASCULAR (CV)

☐ **NONE**
☐ chest pain
☐ color change in feet/legs
☐ leg cramping
☐ leg swelling
☐ pain in calves when walking
☐ varicose veins
☐ pain in feet at night

ENDOCRINE

☐ **NONE**
☐ delayed wound healing
☐ excessive thirst
☐ fatigue

GENITOURINARY

☐**NONE**
☐difficulty with urination
☐burning urination
☐frequent urination

GATROINTESTINAL (GI)

☐ **NONE**
☐ abdominal pain
☐ blood in stool
☐ constipation
☐ diarrhea
☐ nausea
☐ vomiting
☐ yellowing of skin

INTEGUMENTARY

☐ **NONE**
☐ burning sensation of skin
☐ excessive scars (keloids)
☐ itchy skin
☐ non-healing wound

MUSCULOSKELETAL (MSK)

☐ **NONE**
☐ ankle pain
☐ foot pain
☐ hip pain
☐ joint swelling
☐ leg weakness
☐ low back pain
☐ radiating pain down leg

NEUROLOGICAL

☐ **NONE**
☐ burning of feet
☐ electric shooting pain in foot
☐ increased sensitivity to touch
☐ numbness of feet or toes
☐ tingling or pricking sensation

RESPIRATORY

☐ **NONE**
☐ chest tightness
☐ shortness of breath
☐ wheezing

NAME: ______________________________

TODAY'S DATE: ________-______-______

SIGNATURE:_____________________________

ADVANCED FOOT AND ANKLE CENTER

92 SOUTH STATE STREET, VINELAND, NJ 08360

DR. JEFFERY KATZ - DR. JOSEPH BISIGNARO - DR. JORDAN KATZ

Today's Date: ____________________________

Patient's Name____ Date of Birth _______-_______-_______ Age _________

Family Physician ____ SHOE SIZE ________ HEIGHT_________ WEIGHT __________

Pharmacy Name ____________________________ Location _________________________________ Phone ( ) _______-______________

DIABETIC: ☐ Yes ☐ No IF YES WHAT WAS MOST RECENT HbA1c : _______

STORY OF PRESENT ILLNESS:

What is the reason for your visit today? (CHIEF CONCERN) ____

Nature of the problem (NATURE): ☐Dull Pain ☐Sharp Pain ☐Burning ☐Numbness ☐ Weakness ☐Tingling ☐Radiating ☐Other _____________

What is the location of the problem? (LOCATION) ____

How long has your foot/ankle been bothering you (DURATION)? ________________________________

What was the onset of your problem? (ONSET) ☐ Due to Injury ☐Sudden Onset ☐Slow Onset ☐Unknown ☐Other_________________

IF INJURY:

How did it happen? ____

Where did the problem occur? ☐Work ☐Home ☐Store ☐Gym ☐Other ________________________

What happened? ☐Twisting ☐Dropped object ☐Stubbed Toe ☐Fall ☐Other ________________________

What course has this condition taken (COURSE): ☐Worsened ☐Improved ☐Unchanged

What aggravates the problem?(AGGRAVATING FACTORS) ☐Standing ☐Walking ☐Running ☐Stairs ☐Standing after a period of rest ☐Shoes ☐Barefoot

Previous Treatment? (TREATMENT) ☐Ice ☐Advil / Ibuprofen ☐Rest ☐Compression ☐Other

Have you been treated by another physician? ☐Yes ☐No Physician: ___________________ Treatment:___________________

Did you have a study done? : ☐X-ray ☐MRI Where? _________________