Functional Foot and Ankle
Dr. Gerald Mauriello Jr, DPM
500 Greenwich St, Belvidere NJ 07823 Phone: 908-475-8750 Fax: 908-475-8755

Patient Information:

Last Name:_____First Name:_____M:_____Nickname:_____

Date of Birth:_____Age:_____Sex: FEMALE / MALE Martial status: M - D - W - _____

Mailing Address:_____City/State/Zip:_____

Phone:(_____)_____(please circle HOME / CELL / WORK) Email:_____

Employer Name:_____Occupation:_____

Emergency contact/Phone#/relationship:_____

Responsible Party - If the patient is a minor (under 18), the parent or guardian bringing the patient unwell be listed as the guarantor. (If N/A skip)
Last Name:_____First Name:_____Date of Birth:_____

Relationship to patient:_____Address if not same as above:_____

Family Member(s) or other person(s) authorized to share my medical information with:

Name/relationship:_____Name/realtionship:_____

Insurance Information (Office to make copy of insurance card, if subscriber is different then the above information please fill out.)
Please circle if this information below is for your: PRIMARY INSURANCE / SECONDARY INSURANCE / TERTIARY INSURANCE
Last Name:_____First Name:_____Date of Birth:_____

Relationship to patient:_____Address if not same as above:_____

I certify that I have read and agree to Functional Foot & Ankle/NJ Foot and Ankle Restoration, LLC's payment and financial policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Functional Food & Ankle/NJ Foot and Ankle Restoration, LLC. Further, I authorize Functional Food & Ankle/NJ Foot and Ankle Restoration, LLC to obtain needed information from my physician(s), employer or insurance company. I authorize the Functional Food & Ankle/NJ Foot and Ankle Restoration, LLC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Functional Foot & Ankle/NJ Foot and Ankle Restoration, LLC's for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $35.00 returned check fee will be charged for checks returned due to insufficient funds. I understand that I am responsible for any and all authorizations and or referrals needed per my insurance policy. All payments are due at time of service (copayments/coinsurance and or deducible amounts) and or any balance on account. All health plans are not that same and can change without notice, I agree that if there is a service and or DME charge that is not covered I have agreed and signed an ABN and will be responsible for payment of said service or DME charge.
I acknowledge that I have reviewed and or received a copy of the Functional Foot & Ankle/NJ Foot and Ankle Restoration, LLC's Notice of Privacy Policies. This notice describes how the office named above may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. My information is available for disclosure to those I have named on page one (if applicable.)

I have reviewed a copy of the Authorization to Release/Obtain Information, Assignment of Benefits, Payment and Financial Policy, and the Notice of Privacy Practices. _____ (Initials)

Signature of Responsible Party:_____Date: _____

Printed Name of Responsible Party:_____Relationship to Patient: _____

Patient Name:_____ DOB:_____

Clinical Information:

Primary Care Physician/Phone #:_____Pharmacy/location:_____

Allergies: Please List all medications, metals, dyes, latest or foods. ** If you have list of your allergies and medications we will make a copy and you can skip the section**

Allergy List:	Reaction:

Medications: Please list all mediations or supplements including birth control and over-the-counter medications you are currently taking.

Name:	Dose/Taken:	Reason:

Briefly describe the reason for your visit:_____

Duration of this problem: _____Days _____Weeks _____Months _____Years

Was this a work-related injury/problem? _____Yes _____No

If there is pain, please describe it: (check all that apply) _____Sharp _____Dull _____Aching _____Itching _____Stabbing _____Burning _____Other_____

Have you been treated for this problem before? ___ Yes ____No
If yes, briefly describe past treatment_____

Family History:

Do any of these diseases run in your immediate family - Mother (M) Father (F) Sister (S) Brother (B)

Mother Living ____ Father Living ____ Sister Living ____ Brother ____

No Medical Condition: M - F - S - B Heart Disease: M - F - S - B Asthma: M - F - S - B

High Blood Pressure: M - F - S - B Cancer: M - F - S - B: _____ Orthopedic Problems: M - F - S - B

Rheumatoid Arthritis: M - F - S - B Stroke: M - F - S - B Diabetes Insulin dependent: M - F - S - B

Diabetes Non-insulin dependent: M - F - S - B Other: M - F - S - B:_____

Patient Name:_____ **DOB:**_____

Review of Symptoms: Please mark if you currently have or have had in the past year:

General: _____Weight loss or gain _____Fever or chills _____Trouble sleeping _____Fatigue _____Weakness

Gastrointestinal: _____Stomach pain _____Appetite changes _____Nausea _____Bowel changes _____Constipation _____Gas _____Diarrhea _____Rectal Bleeding _____Bloating _____Vomiting

Eye, Ear, Nose, Throat: _____Double/blurred vision _____Headache _____Decreased hearing _____Earache _____Ringing in ears _____Nosebleeds _____Sinus problem _____Persistent cough

Cardiovascular: _____Chest pain/discomfort/tightness _____Palpitations _____High blood pressure _____Edema _____Irregular heart beat _____Poor circulation _____Varicose veins

Skin: _____Rashes _____Itching _____Color changes _____Sore won't heal _____Dryness. _____Bruise easily _____Hair/nail changes

Musculoskeletal: _____Muscle/joint pain _____Back pain _____Swelling of joints _____Stiffness _____Trauma

Urinary: _____Frequency _____Urgency _____Burning or pain _____Blood in urine _____Lack of bladder control

Medical History: Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	YES	NO		YES	NO
No Known Medical problems	_____	_____	Heart Murmur	_____	_____
AIDS/HIV	_____	_____	Hepatitis/Jaundice	_____	_____
Arthritis	_____	_____	High Blood Pressure	_____	_____
Artificial Heart Valves or Joints	_____	_____	High Cholesterol	_____	_____
Bleeding disorders (blood thinners)	_____	_____	Kidney Problems	_____	_____
Cancer: _____	_____	_____	Peripheral Vascular Disease	_____	_____
Coronary Artery Disease/Heart Disease	_____	_____	Stroke	_____	_____
Diabetes	_____	_____	Tuberculosis	_____	_____
Deep Vein Thrombosis (foot/leg clots)	_____	_____	Osteoarthritis	_____	_____
Other: _____				_____	

Past Surgical History:

Please list any operations you have had in the past (date or age can be approximate)

	Type	Date/Age
( ) No previous surgery		
( ) Foot/Ankle/Knee		
( ) Other Surgery		

Patient Name:_____ **DOB:**_____

Social History:

Marital Status: ( ) Married ( )Divorced ( )Single ( )Other

Do you smoke: ( ) Yes ( ) No If yes, how many packs per day? _____Age started:_____

If you are a past smoker, when did you quit and amount previously smoked? _____

Do you use chewing tobacco: ( ) Yes ( ) No If yes, how many tins/pouches_____ How many years?____

Do you use alcohol: ( ) Occasional ( ) Moderate ( ) Heavy
Do you drink coffee: ( ) Occasional ( ) Moderate ( ) Heavy
Do you exercise: ( ) Occasional ( ) Moderate ( ) Heavy
Abused prescription drugs: ( ) Yes _____( ) No
Used recreational drugs: ( ) Yes _____( ) No
Used other performance enhancing substances: ( ) Yes _____( ) No

Recreational Activities: (sports, hunting, fishing, gardening, hobbies) _____

What statement describes your current employment situation (check all that apply):

( ) Currently working ( ) Retired (not due to health issues ( ) Unemployed ( ) Disabled

Consent/Authorization for Treatment

I hereby consent and give permission to Dr. Gerald Mauriello (and any assistants or designated replacements) to administer and/or perform such procedures/x-rays/injections and or any treatment upon me as the Doctor deems necessary. I understand that this authorization is voluntary and I may refuse to provide authorization. I understand that I am ultimately responsible for the charges related to my treatment as per the Assignment of Benefits and the Payment and Financial Policies as signed on my demographic registration forms.

I confirm that I am the parent or legal guardian of the above-referenced minor. I hereby authorize Dr. Gerald Mauriello (and any assistants or designated replacements) provide medical care as it so deems necessary to the minor. In the event that the minor has received treatment at prior to the date of this form, I hereby authorize treatment in addition to the treatment(s) of a prior date.

Signature of Patient/Guardian:_____ **Date:**_____

Relationship to patient: _____