Family Focused Foot & Ankle *Dr. Gerald Mauriello, Jr.*
254B Mountain Avenue, Suite 100 ● Hackettstown, NJ 07840 ● 908-2017313

Patient Information

Name_____
Last Name *First Name* *Middle Initial* Home Phone ( )_____
Address_____Cell Phone ( )_____.
City _____State _____ Zip _____
Email _____.
Sex [ ] Male [ ] Female Age_____ Birthdate _____ [ ] Married [ ] Widowed [ ] Single [ ] Minor
[ ] Separated [ ] Divorced [ ] Partnered
Patient Employer/School _____ Occupation_____.
Whom may we thank for referring you? _____.
In case of emergency who should we contact?_____ Phone ( )_____.
Who is your Primary Care Physician? _____ Located at _____
What is your preferred Pharmacy? _____Phone # or Location_____

Primary Insurance

Person responsible for account_____.
Last Name *First Name* *Middle Initial*
Relationship to patient_____ Birthdate_____.
Insurance Company _____.

Additional Insurance

Subscriber Name_____ Birthdate_____Relationship to patient_____.
Insurance Company _____.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____ and
Name of Insurance Companies
Assign directly to **Dr. Mauriello** all insurance benefits, if any, otherwise payable to me for services rendered. I Understand that I am financially responsible for all charges whether or not paid by insurances. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment is completed.

_____ **Date**_____.
Signature of Patient, Parent or Guardian or Personal Representative

_____ . _____.
Please Print Name of Patient, Parent or Guardian or Personal Representative **Relationship to Patient**

Allergies – Please list all medications, metals, dyes, latex or foods. If you have a paper list of your medications or allergies we will make a photocopy of them.

Allergy List	*Reaction*

Medications – Please list all medications or drugs including birth control pills, over-the-counter medications or herbal supplements you are currently taking.

Drug or Medicine	*Amount/Dose*	*Start Date*	*Stop Date*	*Stop Reason*

Registration Form

Confidential

Patient Name_____Height _____Weight _____.

Age_____ Birthdate_____ Date of last physical exam_____.

What is your reason for your visit?_____.

Symptoms

Check X conditions you currently have or have had in the past year

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problem
- ☐ Vision flashes/halos

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

SKIN

- ☐ Bruise easily
- ☐ Hives / Rash
- ☐ Itching
- ☐ Change in Moles
- ☐ Sore that won't heal
- ☐ Scars

MUSCLE/ JOINT/ BONE

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Lack of bladder control

Medical History

- ☐ No medical problems
- ☐ DEXA Scan or Bone Density Scan
- ☐ History of MRSA
- ☐ Claustrophobic or fearful of enclosed spaces
- ☐ Diabetes, Insulin-Requiring
- ☐ Diabetes, Non-Insulin
- ☐ Asthma
- ☐ Pulmonary Embolism (Blot Clot Lung)
- ☐ Deep Vein Thrombosis (Blood Clot Leg)
- ☐ Thyroid Disorder
- ☐ HIV or AIDS
- ☐ Leukemia or Lymphoma
- ☐ Organ Transplant
- ☐ Heart Attack
- ☐ Coronary Artery Disease / Heart Disease
- ☐ Heart Arrhythmia
- ☐ Heart Murmur
- ☐ Stroke or Mini-stroke
- ☐ High Blood Pressure
- ☐ Bleeding Disorder and/or Factor V, Factor VIII deficiency
- ☐ Emphysema or COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Malignant Hyperthermia
- ☐ Peripheral Vascular Disease
- ☐ Hiatal Hernia / Reflux Disorder
- ☐ Peptic Ulcer Disease
- ☐ Diverticulitis
- ☐ Urinary Tract Infections
- ☐ Kidney Stones
- ☐ High Cholesterol
- ☐ Osteoarthritis
- ☐ Migraine Headaches
- ☐ Cancer type_____
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Psoriasis or Other Skin Disease
- ☐ Poliomyelitis
- ☐ Psychiatric Disorder
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Drug Addiction
- ☐ Glaucoma
- ☐ Dialysis / Renal Failure
- ☐ Reflex Sympathetic Dystrophy (CRPS)
- ☐ Rheumatoid Disease
- ☐ Pacemaker

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 Living _____

- ☐ No medical conditions M F S B
- ☐ Asthma M F S B
- ☐ Back Problems M F S B
- ☐ Cancer M F S B
- ☐ Diabetes Insulin Dependent M F S B
- ☐ Diabetes Non-Insulin Dependent M F S B
- ☐ Heart Disease M F S B
- ☐ High Blood Pressure M F S B
- ☐ Orthopedic Problems M F S B
- ☐ Rheumatoid Arthritis M F S B
- ☐ Stroke M F S B
- ☐ Other

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Do you smoke? ☐ Yes ☐ No

If yes, how many packs a day? _____ If yes, age started? _____

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

Do you use chewing tobacco? ☐ Yes ☐ No If yes, how many tins/pouches? _____ How many years? _____

Do you use alcohol? _____	*Do you drink caffeine?* _____	*Do you exercise?* _____
Occasional ☐	*Occasional* ☐	*Occasional* ☐
Moderate ☐	*Moderate* ☐	*Moderate* ☐
Heavy ☐	*Heavy* ☐	*Heavy* ☐

Abused Prescription Drugs : If yes check box ☐ _____

Used Recreational Drugs : If yes check box ☐ _____

Used Anabolic Steroids : If yes check box ☐ _____

Used Other Performance Enhancing Substances : If yes check box ☐ _____

Recreational Activities (sports, hunting, fishing, gardening, hobbies, etc.) _____

***OCCUPATIONAL HISTORY*:**

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

☐ Retired (not due to health) ☐ Currently working ☐ Unemployed ☐ Homemaker ☐ On Unpaid Leave ☐ On Paid Leave ☐ Disabled

Employer: _____

What is your primary occupation (if not working, what was your primary occupation)? _____

How many years have you been with your current employer? _____

If not working, how long has it been since you stopped? _____

***PAST SURGICAL HISTORY*:** Please list any operations you have had in the past & date or approximate age at the time of procedure

Check any of these if they apply	*Date or age of surgery*
☐ No previous surgery	
☐ Foot/Ankle/Knee	
☐ Other Surgery	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I hereby consent and give permission to Dr. Gerald Mauriello and the Doctor's Assistants or designated replacements to administer and/or perform such procedures upon me as the Doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**