OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

Patient Name:____

Home Phone_____________________________Mobile__________________________________

Address:____

City: ____ State: ________ Zip: ___________

Date Of Birth: _______________ Age: _______ Social Security #: _______________________

PLEASE CIRCLE: Female / Male Married / Single / Other

Employed By: ________________________________ Occupation:_______________________

Business Phone:_________________________Address:_________________________________

City: ____ State:_________ Zip:____________

PHARMACY: ____________________________________ Phone: ____________________

Primary Care Physician:____ Phone: ____________________

Please list any specialists currently treating you:

Specialist: ____ Specialty: ________________

Specialist: ____ Specialty: ________________

Specialist: ____ Specialty: ________________

In Case of an Emergency, whom may we contact? __________________________________

Relationship: _______________________________Phone Number: _______________________

Whom May We Thank for Referring You? ____

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 SO CHOSE) AND UNDERSTOOD THE NOTICE.

____ ________________________

SIGNATURE DATE

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name:____

Date of Birth: ______________________________________

I request that all communications to me (by telephone, mail or otherwise) by Ocean County Foot & Ankle Surgical Associates and/or its staff be handled in the following manner:

- For **Written** Communication: Address to:

  ____

  ____

  ____

- For Oral Communication: Call Telephone #: _____________________________________

  We may discuss your medical history with (Name & Relationship to You):

  ____

  We may discuss your bill with (Name & Relationship to You):

  ____

Patient Signature:
____

Date: _________________________________

- -

For Practice Use Only

Practice: Accepts Denies

Entered (Initial & Date): ______________________________

Date: ____________________________________

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

Assignment of Benefits, Release Form & Financial Policy

Patient Name: ____________________

Primary Insurance: ____________________

Policy Number :____________________ Group Number: ____________________

Subscriber Name: ____________________ Date of Birth: ____________________

Subscriber Employer: ____________________

Secondary Insurance: ____________________

Policy Number : ____________________ Group Number: ____________________

Subscriber Name: ____________________ Date of Birth: ____________________

Subscriber Employer: ____________________

Do you have prescription drug coverage? YES NO

Is today's visit related to an auto accident or workmen's comp. claim? YES NO

***** If the above question applies to you, please fill out the reverse side of this form *****

I hereby instruct and direct the mentioned insurance companies to pay by check, made out and mailed to:
Ocean County Foot & Ankle Surgical Associates
54 Bey Lea Road, Suite 1
Toms River, NJ 08753
for the professional or medial expense benefit allowable, otherwise payable to me.
This is a direct assignment of my rights and benefits under this policy.

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered
- I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.
- I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: ____________________ Date: ____________________

Relationship (if not self): ____________________

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

AUTO ACCIDENT / WORKERS COMPENSATION

Patient Name: ____

AUTO/COMP Insurance Carrier: ______________________________________

Claims Address: ____

____

Claim Number: ____

Date Of Accident/Loss: ____

Adjusters Name & Telephone Number: ________________________________

____

Adjusters Fax Number: ____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Signature: ____

Relationship (If not self):____

Date Signed: ____