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

Name:_____ SS#: _____

Date of Birth: _____ Age: _____ Home Phone #: _____

Cell#: _____ Email: _____

Address:_____

City: _____ State: _____ Zip: _____

PLEASE CIRCLE: Female / Male Married / Single / Other

Race: White / American Indian / Asian / African American / Other: _____

Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Primary Language: _____

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: _____

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. TO ASSIST IN THE COORDINATION OF MY CARE, I HEREBY GIVE WRITTEN CONSENT TO THE DOCTORS OF OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, PC TO VIEW MY PRESCRIPTION HISTORY PROVIDED THROUGH ELECTRONIC HEALTH RECORD EXCHANGE.

_____ _____

SIGNATURE 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): _____

****

For Office Use Only:

□ Insurance Card & ID Scanned _____ by _____
Date Initials

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: _____

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 (Initials): _____

Date: _____