

**Associated Podiatric Physicians, P.A.**

**Donald C. Manger, D.P.M.**

**Matthew S. Blutfield, DPM**

**1300 South Olden Avenue**

**Hamilton, New Jersey 08610**

**Phone: 609-586-7111**

**Fax: 609-586-7311**

DATE: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

How did you hear about us? (Please circle) Internet? , Your Doctor? - If so Doctor's name? \_\_\_\_\_

Friend/Family? If so, who? \_\_\_\_\_ Other reason?- Please specify \_\_\_\_\_

**History of Present Illness**

(Use other side of page if necessary)

What specific problem brings you to our office today?

\_\_\_\_\_

\_\_\_\_\_

Where is the pain/condition located? \_\_\_\_\_

How long ago did this problem first start? \_\_\_\_\_

How would you describe the nature of your pain?  Sharp  Dull  Aching  Burning  Radiating  
 Itching  Stabbing  Throbbing  Soreness  Other

\_\_\_\_\_

How would you rate your pain on a scale from 0 to 10 if 10 were the worst?

1  2  3  4  5  6  7  8  9  10

What seems to make the pain/condition feel worse?  Walking  Standing  Resting  Dress Shoes  
 Flat Shoes  Any Closed Shoes  Daily Activities  Exercise.

\_\_\_\_\_

What makes condition feel better? \_\_\_\_\_

Have you been treated by any other physicians for this condition. If so, what was done for you?

\_\_\_\_\_

Did you have X-rays or any other tests performed related to this problem?  Yes  No

If yes where did you have the X-rays/testing performed? \_\_\_\_\_

Is this problem the result of an injury?  Yes  No If yes, is it work related?  Yes  No

What do you do for exercise? \_\_\_\_\_

**REVIEW OF SYSTEMS:** Are you **NOW** experiencing any of the following?

**Constitutional**

- Appetite Loss  Yes  No
- Weight Loss/Gain  Yes  No
- Fever/Chills  Yes  No
- Nausea/Vomiting  Yes  No

**Cardiovascular**

- Chest Pain  Yes  No
- Heart Disease  Yes  No
- Varicose Veins  Yes  No
- Cool Extremities  Yes  No
- Hypertension  Yes  No
- Hair Loss Legs  Yes  No
- Leg pain when walking  Yes  No

**Psychiatric**

- Anxiety  Yes  No
- Depression  Yes  No
- Memory Loss  Yes  No

**Endocrine**

- Diabetes  Yes  No
- Fatigue  Yes  No
- Excess Thirst  Yes  No
- Heat/Cold Intolerant  Yes  No
- Excess Urination  Yes  No

**Genitourinary**

- Burning or Painful Urination  Yes  No
- Kidney Stones  Yes  No
- Dialysis  Yes  No
- Kidney Disease  Yes  No

**Ear/Nose/Mouth/Throat**

- Nose Bleeds  Yes  No
- Sinus Problems  Yes  No
- Hearing Loss  Yes  No
- Difficulty Swallowing  Yes  No
- Sore Throat  Yes  No

**Gastrointestinal**

- Abdominal Pain  Yes  No
- Hepatitis  Yes  No
- GERD/Heartburn  Yes  No
- Ulcer of GI Track  Yes  No
- GI or Rectal Bleeding  Yes  No

**Skin**

- Athletes Foot  Yes  No
- Ingrown Nails  Yes  No
- Rash  Yes  No
- Corns/Callus  Yes  No
- Lumps  Yes  No
- Ulcers/Wounds  Yes  No
- Fungal Nails  Yes  No
- Mole Changes  Yes  No
- Warts  Yes  No

**Hematological**

- Blood Clots  Yes  No
- Phlebitis  Yes  No

**Eyes**

- Blurred/Double Vision  Yes  No
- Eye Disease or Injury  Yes  No
- Wear Glasses/Contacts  Yes  No

**Respiratory**

- Difficulty Breathing  Yes  No
- TB  Yes  No
- Lung Disease  Yes  No
- Shortness of Breath  Yes  No

**Musculoskeletal**

- Arthritis  Yes  No
- Gout  Yes  No
- Back Pain  Yes  No
- Joint Pain  Yes  No
- Cramps Leg/Feet  Yes  No

**Neurological**

- Burning/Tingling/ Numbness  Yes  No
- Stroke/TIA  Yes  No
- Chemotherapy  Yes  No
- Speech Disorder  Yes  No

**Allergic/Immunologic**

- Hives  Yes  No
- Itchy/Watery Eyes  Yes  No
- Sneezing/Runny Nose  Yes  No

Please list any conditions that you have been diagnosed with:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Allergies:**  None Known  Adhesive Tape  Aspirin  Cephalosporins  Codeine  Erythromycin  
 Flu Shot  Iodine  Latex  Lidocaine  NSAIDS  Penicillin  Quinolones  Sulfa Drugs  Tetracycline  
 Other medications (Please list) \_\_\_\_\_

**Medications** you are currently taking (Including prescriptions, over-the-counter meds and herbal supplements): **(If you have a printed list, we can photocopy it for you)**

NAME

- |          |          |           |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____  |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

**FAMILY HISTORY: Do you have a FAMILY history of any of the following?**

Psoriasis Y N? If yes who in your family? \_\_\_\_\_  
Rheumatoid Arthritis Y N ? If yes, who in your family? \_\_\_\_\_  
Cancer Y N ? If yes, who in your family? \_\_\_\_\_  
Diabetes Y N ? If yes, who in your family? \_\_\_\_\_  
Gout Y N ? If yes, who in your family? \_\_\_\_\_  
Heart Disease Y N ? If yes, who in your family? \_\_\_\_\_  
High blood pressure Y N ? If yes, who in your family? \_\_\_\_\_  
Multiple Sclerosis ( MS) Y N ? If yes, who in your family? \_\_\_\_\_  
Peripheral Neuropathy Y N ? If yes, who in your family? \_\_\_\_\_  
Poor Circulation Y N ? If yes, who in your family? \_\_\_\_\_  
Stroke Y N ? If yes, who in your family? \_\_\_\_\_

**PAST MEDICAL HISTORY: Have YOU ever had any of the following IN THE PAST?**

Peripheral Neuropathy	Y N	HIV	Y N	Blood Clot	Y N
Arthritis	Y N	Kidney Disease	Y N	Cancer	Y N
Heart Disease	Y N	Dialysis	Y N	Fibromyalgia	Y N
Dementia	Y N	Ulcer Foot	Y N	Hepatitis	Y N
Gout	Y N	Acid Reflux (GERD)	Y N	Pneumonia	Y N
High Blood Pressure	Y N	Back Problem	Y N	Thyroid Disease	Y N
Polio	Y N	COPD	Y N		
Ulcer (GI)	Y N	Diabetes	Y N		
Sickle Cell	Y N	Migraine	Y N		
Asthma	Y N	Heart Attack	Y N		
Congestive Heart Failure	Y N	TB	Y N		
Dermatitis	Y N	Anemia	Y N		

**Women Only: Are you pregnant? Y N Are you nursing? Y N**

**Social History:**

Do you smoke?  Yes  No If yes, what type/frequency? \_\_\_\_\_  
If you don't smoke now, did you ever smoke?  Yes  No. If yes, when did you quit? \_\_\_\_\_  
Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_  
Do you use or have used recreational drugs?  Yes  No If yes, what type/frequency? \_\_\_\_\_

**Please List All Prior Surgeries/Hospitalizations:**

Why?	Date	Why?	Date
1 _____		4 _____	
2 _____		5 _____	
3 _____		6 _____	

**Patient Information:**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Male  Female

Race:  Amer Indian  Asian  Black/African American  Hisp/Latino  Hawaiian/Pacific  White

Ethnic group:  Hispanic/Latino  Not Hispanic/Latino

Preferred Language \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address \_\_\_\_\_

Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

What phone number do you prefer we use?:  Home  Work  Cell

Email address \_\_\_\_\_. Is it acceptable for us to email/text you?  Yes  No

Emergency Contact: First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Marital Status  Single/never married  Married  Partnered  Widowed  Separated  Divorced

Are you employed?:  Yes  No  Student  Retired  Child  Other

Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Occupation \_\_\_\_\_

Are you a Diabetic?:  Yes  No

Doctor who manages your diabetes: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Primary Physician Name: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

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**Insurance information:**

**Please provide us with a copy of your insurance cards and photo identification.**

Does your insurance policy require a referral?  Yes  No

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Insurance Co. \_\_\_\_\_

Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

**INSURANCE ASSIGNMENT AND RELEASE**

- 1) By signing below, I certify that I have insurance coverage with the above named insurance company and I assign directly to Dr. Donald C. Manger 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 insurance. I authorize the use of my signature on all insurance submissions.  
The above-named doctor may use my health care information and may disclose such information to the above-named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**(MEDICARE/MEDIGAP AUTHORIZATION (For those patients that have Medicare/Medigap))**

- 2) By signing below, I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Donald C. Manger for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.
- 3) By signing below, I certify that to the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

- 1) 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.

\_\_\_\_\_  
Print Name of Patient, Parent or Guardian      Signature of Patient, Parent or Guardian      Date

# E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

**Formulary and benefit transactions** - gives the prescriber information about which drugs are covered by the drug benefit plan.

**Medication history transactions** – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Associated Podiatric Physicians, PA to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Associated Podiatric Physicians, PA, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Associated Podiatric Physicians, PA medical record.

Understanding all of the above, I hereby provide informed consent Associated Podiatric Physicians, PA to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain in force until revoked or changed.

Patient Name (PLEASE PRINT) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

ASSOCIATED PODIATRIC PHYSICIANS, PA

Donald C. Manger, DPM  
Matthew S. Blutfield, DPM  
1300 South Olden Ave  
Hamilton, NJ 08610  
Phone (609) 586-7111 Fax (609) 586-7311

**Office Financial Policy**

- 1) On arrival, please sign in at the front desk and present your current insurance card and photo ID at every visit. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit
- 2) Payment is expected at the time of service. This includes co-payments or coinsurance for participating insurance companies. Associated Podiatric Physicians, accepts cash, personal checks, VISA, MasterCard and Discover Card.
- 3) Patients with an outstanding balance more than 30 days overdue must make arrangements for payment prior to scheduling appointments. Past due accounts are subject to collection proceedings. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due , as well as all reasonable collection costs not to exceed 50% of the balance, court costs, attorney fees and interest fees accrued with the collection of this account
- 4) As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. It is your responsibility to be sure your referral is current.
- 5) Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- 6) All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- 7) There is a service fee of \$25.00 for all returned checks.
- 8) If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. If you do not call a \$25.00 fee may be charged.
- 9) Please call if you have a question about your bill. Most problems can be settled easily and your call will prevent misunderstandings. If you are having trouble paying your bill, please tell us as satisfactory arrangements can almost always be made. Financial concerns should never prevent you or your family member from receiving the care they need.

I have read and understand this office financial policy and agree to comply with this policy.

Date: \_\_\_\_\_ Print Patient Name: \_\_\_\_\_

If minor name of responsible party: \_\_\_\_\_

Signature of patient/responsible party: \_\_\_\_\_