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MICHAEL RALLATOS, D.P.M., A.A.C.F.A.S.
KAITLIN DICKERT GONZALES, D.P.M., A.A.C.F.A.S.
ELIZABETH ANTHONY, D.P.M., A.A.C.F.A.S.
ASHLEY BITTAR, D.P.M., A.A.C.F.A.S.

Diplomate American Board of Podiatric Surgery
Diplomate American Board of Orthopedics

528 Boulevard
Kenilworth, NJ 07033
Phone: (908) 276-6624
Fax: (908) 709-0163

PATIENT INFORMATION SHEET

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: □ Male □ Female

Social Security # _____-_____-_____ Birth Date: _____

Street address: _____ City _____State:_____ Zip_____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Marital Status: □Single □Married □Divorced □Widowed Age: _____ Weight _____lbs Shoe Size _____

Responsible Party (if patient is a minor): _____ Relationship: _____
Full Name

Emergency Contact: _____ Phone: (_____) _____Relationship: _____

Pharmacy Name: _____ Pharmacy Phone: (_____) _____

INSURANCE INFORMATION:

Are you covered under any other Medical Insurance? Secondary Policy? □ Yes □ No
Who is your primary care physician? _____ Physician Phone: (_____) _____

Office Location: _____
City/Town/State

EMPLOYMENT INFORMATION:

Occupation: _____ Patient employed by: _____

Business Address: _____

MEDICAL HISTORY:

Current Foot/Ankle Problem: _____

Current Foot Problem Related to Work Injury or Auto Accident? _____

Do you have or have you ever been treated for:

□ GERD	□ Heart Attack	□ Psychiatric Disorder
□ Stomach Ulcer	□ High Blood Pressure	□ Alzheimer's Disease
□ Liver Disease	□ High Cholesterol	□ Epilepsy
□ Hepatitis	□ Arrhythmia	□ Fibromyalgia/ RSD
□ AIDS/HIV	□ Valvular Heart Disease	□ Stroke
□ Hypothyroid	□ Asthma	□ Hearing/ Ear Disorder
□ Hyperthyroid	□ Lung Disease	□ Glaucoma
□ Diabetes	□ Rheumatoid Arthritis	□ Nerve Disorder
□ Poor Circulation	□ Arthritis	□ Sciatica
□ Kidney Disease	□ Osteoporosis	□ Cancer _____
□ Anemia	□ Gout	□ Other _____

List any past surgical history: _____

List current medications: _____

_____

Allergies to medications? _____

Do you? □ Smoke Tobacco □ Drink Alcohol Regularly □ Recreational Drug Abuse

Family History: □ Diabetes □ Heart Disease □ Poor Circulation □ Foot problems □ Other

Whom may we thank for referring you? _____

SIGNATURE OF PATIENT: _____

Part One:

Acknowledgment Of Receipt of Notice Of Privacy Practices

I acknowledge that I was provided with 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 - Patient Name
Or Parent/Authorized Representative Name (*if applicable*)

_____ _____

Signature of Patient Date
Or Parent/Authorized Representative

Part Two:

Authorization to Pay Benefits To Physician

I hereby authorize and request payment directly to Dr. Sean Kaufman, Dr. Michael Rallatos,Dr. Kaitlin Dickert Gonzales, Dr Elizabeth Anthony and/or Dr. Ashley Bittar for any surgical and/or medical benefits due under the terms of this insurance policy for services rendered.

_____ _____

Signature of Patient Date
Or Parent/Authorized Representative

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PATIENT INFORMATION SHEET

Patient Name: _____

Please take a minute to complete this form prior to being seen today.

1) Height _____

2) Weight _____

3) Recent Blood Pressure _____

4) Are You a Current Smoker? □Yes □No □ Previous

5) Have you had the flu shot this year? □Yes □No
Pneumonia shot? □Yes □No

6) Any falls within the past 12 months? □Yes □No

7) Do you have any advanced directives? □Yes □No

If yes: □ DNR □ Living Will Order □Power of Attorney
□ Surrogate Decision Maker □ Prefer not to answer

Please provide our office with a copy of this information.

E-mail address to access our patient portal:

_____ or Already provided