



**SEAN L. KAUFMAN, D.P.M., F.A.C.F.A.S.**  
**MICHAEL RALLATOS, D.P.M., A.A.C.F.A.S.**  
**POOJA SHAH, D.P.M., A.A.C.F.A.S.**

**ASHLEY BITTAR, D.P.M., A.A.C.F.A.S.**  
**RACHEL MASLOW, 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  
 Tel. 908-276-6624  
 Fax: 908-709-0163

877 Broadway  
 Bayonne, NJ 07002  
 Tel. 201-436-4287  
 Fax: 201-436-5794

119 Grove St.  
 Montclair, NJ 07042  
 Tel. 973-783-5150  
 Fax: 973-783-2821

**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 / location: \_\_\_\_\_ 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:

- |                                           |                                               |                                               |
|-------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> GERD             | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Stomach Ulcer    | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Alzheimers           |
| <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Arrhythmia           | <input type="checkbox"/> Fibromyalgia/RSD     |
| <input type="checkbox"/> AIDS/HIV         | <input type="checkbox"/> Valvular Heart Dz    | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Hypothyroid      | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hearing/Ear Disorder |
| <input type="checkbox"/> Hyperthyroid     | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Nerve Disorder       |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Sciatica             |
| <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Gout                 | <input type="checkbox"/> 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: \_\_\_\_\_



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## PATIENT INFORMATION SHEET

**Patient Name:** \_\_\_\_\_

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

\_\_ Height \_\_\_\_\_

\_\_ Weight \_\_\_\_\_

\_\_ Recent Blood Pressure \_\_\_\_\_

\_\_ Are You a Current Smoker?  Yes  No

\_\_ Have you had the flu shot this year?  Yes  No

Pneumonia shot?  Yes  No

\_\_ Any falls within the past 12 months?  Yes  No

\_\_ 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 ; \_\_\_\_\_ or Already provided

**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  
 Or *Parent/Authorized Representative*

\_\_\_\_\_  
 Date

**Part Two:**

**Authorization to Pay Benefits To Physician**

I hereby authorize and request payment directly to Dr. Sean Kaufman, Dr. Michael Rallatos, Dr. Ashley T. Bittar, Dr. Pooja Shah and/or Dr. Rachel Maslow for any surgical and/or medical benefits due under the terms of this insurance policy for services rendered.

\_\_\_\_\_  
 Signature of Patient  
 Or *Parent/Authorized Representative*

\_\_\_\_\_  
 Date



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**Effective October 1, 2014**

**Please be aware that the doctors do not practice pain management, nor do they prescribe narcotic pain medication. If you are here to obtain a prescription for narcotic pain medication or any other controlled substance, please see the front desk.**

**Thank You,**

**Innovative Foot and Ankle**

**I am aware of the above statement, that Dr. Sean Kaufman, Dr. Micheal Rallatos, Dr. Rachel Maslow, Dr. Pooja Shah and Dr. Ashley Bittar do not prescribe pain medication or controlled substances.**

**Print Patient Name**

**Patient Signature**

**Date**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**SEAN L. KAUFMAN, D.P.M., F.A.C.F.A.S.**  
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**ASHLEY BITTAR, D.P.M., A.A.C.F.A.S**  
**VASILIKI RALLATOS-DRAKE D.P.T.**

**MICHAEL RALLATOS, D.P.M., A.A.C.F.A.S.**  
**JOSEPH G. CABRERA, D.P.M., A.A.C.F.A.S**  
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### Innovative Foot And Ankle P.A.

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time of services are rendered, if I have been granted a grace period for payments of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

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 reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

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Responsible Party Signature

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Date