IN STEP Foot and Ankle Specialists,LLC

Dr. Thomas Cusumano

59-A Kinderkamack Road Westwood, NJ 0767 201-666-4166 Fax: 201-666-4165
26-06 Broadway Fair Lawn, NJ 07410 201-794-8200 Fax 201- 794-8201

PATIENT INFORMATION SHEET

SEX: [ ]Male [ ]Female

First Name:_____M.I._____Last Name:_____

Address:_____Home Phone: ( )_____

City:_____Work Phone: ( )_____

State:_____Zip:_____E-mail:_____

Age:____Birth Date: ____/____/_____ Social Security# _____-_____-_____Marital Status:_____

Occupation_____Employer _____

Employer Address_____

Student info:Year_____School_____Coach_____

Sports & Hobbies : _____

Referred by:_____Family Doctor_____
Town: _____

Medical Insurance:_____Pharmacy _____
Town _____
Phone _____

My chief complaint is:_____

	yes	No	?		yes	No	?	Allergies	Yes	No	?
Foot or leg injuries	[ ]	[ ]	[ ]	Diabeties	[ ]	[ ]	[ ]	Novocaine	[ ]	[ ]	[ ]
Foot or leg surgery	[ ]	[ ]	[ ]	Heart trouble	[ ]	[ ]	[ ]	Penicillin	[ ]	[ ]	[ ]
Foot or leg numbness	[ ]	[ ]	[ ]	Epilepsy / Seizures	[ ]	[ ]	[ ]	Adhesive tape	[ ]	[ ]	[ ]
Foot or leg cramps	[ ]	[ ]	[ ]	Liver Disease	[ ]	[ ]	[ ]	Drugs	[ ]	[ ]	[ ]
Knee pain	[ ]	[ ]	[ ]	Kidney disease	[ ]	[ ]	[ ]	Foods	[ ]	[ ]	[ ]
Unequal leg length	[ ]	[ ]	[ ]	Rheumatic fever	[ ]	[ ]	[ ]	Contrast dye	[ ]	[ ]	[ ]
Weak ankles	[ ]	[ ]	[ ]	High blood pressure	[ ]	[ ]	[ ]	Iodine	[ ]	[ ]	[ ]
Bunions	[ ]	[ ]	[ ]	Polio	[ ]	[ ]	[ ]	Other_____			
Skin problems	[ ]	[ ]	[ ]	Bursitis	[ ]	[ ]	[ ]	_____			
Toe nail problems	[ ]	[ ]	[ ]	Stomach ulcers	[ ]	[ ]	[ ]	_____			
Lower back pain	[ ]	[ ]	[ ]	Asthma	[ ]	[ ]	[ ]]				

_____

_____

I hereby give permission to, Thomas J. Cusumano, D.P.M. and /or Associates for examinations and rendering care for my problem and / or related conditions.

Date_____ Patient Signature (if minor, parents)_____

Parents Name(s) _____ _____

Medical History

First Name:_____ M.I._____ Last Name:_____

Weight_____
Height_____
Shoe size

Birth Date: _____ Date _____

MEDICAL HISTORY	Yes	No	Do not know
Anxiety			
Arthritis			
Asthma			
Cancer			
C H F			
Diabetes Insulin			
Diabetes Non-Insulin			
GI Ulcers			
GI Reflux			
Heart Attack / MI			
Heart Disease			
High Blood Pressure			
Low Blood Pressure			
High Cholesterol			
Hyperthyroid			
Hypothyroid			
Kidney Disease			
Liver Disease			
Murmur			
Vascular Disease			

Surgery: { } None
Vascular Surgery
Heart Surgery
Joint Replacement
Foot & Ankle

SOCIAL HISTORY	No	Yes	Years	Quit
Tobacco				
Alcohol				

FAMILY HISTORY + yes - no

[ ] Diabetes

[ ] Heart Disease

[ ] High Blood Pressure

Other_____

MEDICATIONS { } none
1
2
3
4
5
6
7
8
9
10
11
Sheet attached yes no

ALLERGIES { } None
1
2
3
4

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WELCOME TO OUR OFFICE

PATIENT INFORMATION:
SEX: [ ] MALE [ ] FEMALE]

Marital status:
[ ] single [ ] married [ ] divorced [ ] widow

BIRTH DATE: _____/_____/_____

SOCIAL SECURITY# _____-_____-_____

FIRST NAME: M.I.

LAST NAME :

ADDRESS:

CITY:

STATE: ZIP:

HOME PHONE: ( )

WORK PHONE: ( )

EMAIL :

INSURED'S INFORMATION [ ] Same as Patient
SEX: [ ] MALE [ ] FEMALE

Your Relationship to patient:
[ ] Self [ ] mother [ ] father [ ] spouse [ ]Other _____

BIRTH DATE: _____/_____/_____

SOCIAL SECURITY# _____-_____-_____

FIRST NAME: M.I.

LAST NAME :

ADDRESS:

CITY:

STATE: ZIP:

HOME PHONE: ( )

WORK PHONE: ( )

IS THIS TREATMENT RELATED TO

[ ]WORKMEN'S COMP Authorization # _____

[ ] MVA (Car Accident Injury)

Date of Injury _____/____/_____ Place of Injury_____

IN CASE OF EMERGENCY call _____( )_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____

IDENTIFICATION #_____ Group #_____

ADDRESS (if known)_____

SECONDARY INSURANCE NAME:_____

IDENTIFICATION #_____ Group #_____

ADDRESS (if known)_____

AUTHORIZATION / RESPONSIBILITY AGREEMENT;

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. THOMAS J. CUSUMANO, AND / OR ASSOCIATES AND WILL BE RESPONSIBLE FOR OUTSTANDING BALANCES. A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE TO PAY MY ACCOUNT AS SERVICES ARE PROVIDED. HOWEVER, IF I AM NOW OR IN THE FUTURE BECOME A MEMBER OF A HMO OR MANAGED CARE PLAN I ASSUME THE RESPONSIBILITY AS THE INSURED AND WILL PROVIDE PROPER AUTHORIZATION OR REFERRALS FOR THIS AND UPCOMING VISITS BEFORE MEDICAL CARE IS RENDERED. IF PROPER AUTHORIZATION OR REFERRALS ARE NOT OBTAINED, I AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO THIS OFFICE.

UNDER CERTAIN CIRCUMSTANCES, I MAY HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF; I CLEARLY UNDERSTAND THAT THE BILL IS STILL MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS). IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I AGREE TO PAY PROMPTLY.

SIGNED_____ DATE:_____

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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I may request 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.

Patient Name (please print) Date

X_____
Signature of Patient

SIGNATURE OF FILE

Patient's Name (print) Insured/Medicare Number

I request that payment of authorized insurance and medicare benefits be made either for me or on my behalf to Thomas J. Cusumano, D.P.M and or associates for any services furnished to me by him and or associates. I authorize any holder of medical information concerning me to release to my Insurance carrier or the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits to related services.

X_____ _____
Signature of Patient Date

Yearly renewal of signature on file as described above

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Date

Saved as privacy act letter 10-07