QUALITY FOOT AND ANKLE CENTER

Dr. Michael Milad
55 Leonardville Rd
Belford, NJ 07718
(732) 787-4747

449 Avenue C
Bayonne, NJ 07002
(732) 926-7733

87 Brunswick Woods Dr.
East Brunswick, NJ 08816
(732) 926-7733

Last Name	First Name	Sex M ☐ F ☐	Today's Date:
Marital Status	Address		APT
City	State	Zip Code	
Home phone	Cell Phone	Email Address	
Employer Name	SSN	DOB	

Emergency contact	Relationship	Phone	
Primary care physician	Date last seen	Phone	
Primary care physician address	Referring physician:		
Pharmacy Name	Pharmacy Phone		
Pharmacy Address			

Primary Health Insurance name			
Subscriber's name	Member ID	Group #	Are you currently insured? Y ☐ N ☐
Employer Name	DOB	Sex M ☐ F ☐	Relationship to subscriber:
Secondary Health Insurance name			

Patient's Signature

Date

QUALITY FOOT & ANKLE CENTER

Subscriber's name	Member ID	Group #	Are you currently insured? Y ☐ N ☐
How did you hear about us?			

Do you have history of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes I or II	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Other Conditions:

Current Medication	

Surgery Type	**Date**

Allergies?	**Reaction:**

Patient's Signature

Date

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Use of Alcohol:	○Never	○Occasionally	○Often	○History of Abuse
Use of Tobacco:	○Never	○Occasionally	○Often	○History of Abuse
Use Recreational Drug:	○Never	○Occasionally	○Often	○History of Abuse
Weight:		**Height:**		

Family History	
○ Diabetes ○ Cancer	○Heart Disease ○ High Blood Pressure ○Stroke ○Coronary Artery Disease
○Thyroid Disease	○ Rheumatoid Arthritis ○Other: _____
	Relation: _____

Your visit today

What is the reason for the visit today?
Where is the problem located? ☐ R ☐ L ☐ Heel ☐ Foot ☐ Ankle ☐ Top of foot ☐ Bottom of foot ☐ Outer side of the foot ☐ Inner side of the foot ☐ Outer side of the ankle ☐ Outer side of the Ankle
Is this an accident or work injury?
What is your pain scale? 0 1 2 3 4 5 6 7 8 9 10 (please circle one if applicable)
How long have you been experiencing the problem? 1 2 3 4 5 6 7 8 9 10 Days Weeks Months years
Does the pain/problem radiate in any direction?
Did the pain/problem come on suddenly (possibly due to an injury) or gradually?
Describe the pain: aching, stabbing, throbbing, sharp Dull, Other: (please circle one, or more if applicable)
What makes the pain/problem better or worse?
Have you been treated for a similar problem before? If yes, what was the course of treatment?

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____

Signature

_____

Date

QUALITY FOOT & ANKLE CENTER

Consent to treat, HIPAA and Office Policy

I have been made aware of my condition by my health care provider and agree to have medical care and appropriate podiatric procedures performed at Quality Foot And Ankle Center. The treatment will be in accordance with my diagnosis and in consultation with my physician or health care provider.

I accept to receive automated text and/or voice messages at the phone number(s) provided.

I have also been provided with a copy of Quality Foot And Ankle Center HIPAA Privacy Notice and have been given ample opportunity to read and ask questions about said notice.

I give consent to retrieve prescription history report.

_____ _____

Patient Signature Date

I authorize the release of medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to the providers at Quality Foot And Ankle Center. I permit a copy of this authorization to be used in place of an original. I accept full responsibility for the full amount due for services provided for me.

I understand that all insurance forms that I have signed may be sent to my insurance company or employer on my behalf. Any payments that are received by me for services rendered by Quality Foot And Ankle Center will be endorsed and presented immediately along with an explanation of benefits.

I also understand that any insurance deductibles or co-insurance is my responsibility to pay to Quality Foot And Ankle Center. I also understand that I am responsible to present any information pertinent to the processing of any claims. If my insurance information changes, I must alert the office staff at Quality Foot And Ankle Center immediately.

_____ _____

Patient Signature Date