JAMES P SULLIVAN, D.P.M.
GREG CLARK, D.P.M.

PATIENT INFORMATION (CONFIDENTIAL)

PATIENT NAME_____ SOCIALSECURITY#_____
FIRST MIDDLE LAST

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

CAN A MESSAGE BE LEFT ON MACHINE OR VOICEMAIL: _____YES _____NO

BIRTH DATE_____ AGE_____ _____FEMALE _____MALE HT:____'____" WT:LBS:_____

RACE:_____ ETHNICITY:_____ LANGUAGE: CIRCLE: ENGLISH / OTHER _____

CHECK ONE [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

EMERGENCY CONTACT: NAME_____ PHONE#:_____

RELATIONSHIP TO PATIENT:_____ _____FEMALE _____MALE

ALLERGIES / DRUG ALLERGIES:_____

CHECK IF YES LEAVE BLANK IF NO. [ ] DIABETES [ ] ASTHMA [ ] HEART PROBLEM

[ ] KIDNEY PROBLEM [ ] CIRCULATORY PROBLEMS [ ] SMOKER - PACKS PER DAY_____

CURRENT MEDICATIONS_____

REASON FOR APPOINTMENT_____

REFERRED BY_____

PRIMARY CARE PHYSICIAN_____ PHONE_____
FIRST LAST

ADDRESS:_____ CITY_____ STATE_____ ZIP_____

LAST VISIT TO MD_____ (IF DIABETIC REQUIRED EVERY TIME YOU COME)

PHARMACY INFORMATION: - NAME – ADDRESS - PHONE

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

I HEREBY GIVE CONSENT TO JERSEY SHORE PODIATRIC ASSOCIATES TO OBTAIN ANY INFORMATION REGARDING MY MEDICATIONS FROM MY PHARMACIES OR OTHER DOCTORS.

SIGNATURE:_____ DATE:_____

JAMES P. SULLIVAN, D.P.M.
GREG D. CLARK, D.P.M.

PATIENT INFORMATION (CONFIDENTIAL)

INSURANCE INFORMATION:

PRIMARY HEALTH INSURANCE_____RELATIONSHIP TO PATIENT_____

NAME OF INSURED:_____BIRTHDATE:_____ SOCIAL SECURITY:_____

POLICY#_____GROUP#_____

ADDRESS_____CITY_____STATE_____ZIP_____

SECONDARY INSURANCE_____RELATIONSHIP TO PATIENT_____

NAME OF INSURED_____BIRTHDATE_____SOCIAL SECURITY#_____

POLICY#_____GROUP#_____

ADDRESS_____CITY_____STATE_____ZIP_____

HEREBY ASSIGN INSURANCE BENEFITS TO JAMES P. SULLIVAN, D.P.M FOR ANY SERVICES FOR WHICH THIS OFFICE SUBMITS DIRECTLY TO SAID INSURANCE COMPANY. I GIVE DR. SULLIVANS OFFICE PERMISSION TO FORWARD ANY MEDICAL INFORMATION THAT MAY BE NEEDED TO PROCESS THESE CLAIMS FOR PAYMENT. I UNDERSTAND THAT ANY BALANCE THAT IS DEEMED PATIENT RESPONSIBILITY WILL BE PAID UPON RECEIPT OF AN ITEMIZED BILL.

REFERRALS ARE THE PATIENTS RESPONSIBILITY DUE AT TIME OF VISIT:

COPAYS ARE DUE AT TIME OF VISIT. PAYMENTS FOR NON COVERED ITEMS ARE DUE AT TIME OF VISIT.

_____ _____

SIGNATURE OF PATIENT OR PARENT OR GUARDIAN IF MINOR DATE

Jersey Shore Podiatric Associates
James P. Sullivan, DPM
Greg Clark, DPM

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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.

_____ _____
Patient Name (please print) Date

_____

Parent or Authorized Representative

_____
Signature

MEDICAL INFORMATION CAN BE RELEASED TO:

NAME:_____**RELATIONSHIP:**_____

PHONE NUMBER:_____

NAME:_____**RELATIONSHIP:**_____

PHONE NUMBER:_____