"Put your feet in our hands"

JAMES F DONOVAN, D.P.M.

Jayson K. Choi D.P.M.

104 Commons Way, Building A, Toms River, NJ 08755

Phone: 732-349-1123

Fax: 732-349-6549

PATIENT INFORMATION SHEET

Last Name_____First Name_____Middle Initial_____

Sex: ☐Male ☐Female **Marital Status** ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____Apt:_____

_____ _____ _____

City State Zip

Social Security # _____-_____-_____ Birth Date _____/_____/_____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Ext._____

Occupation_____ Patient employed by _____

☐Full time ☐Part-time ☐Retired

Cell Phone (_____) _____-_____

Preferred Method of Communication: ☐*Cell Phone* ☐*Home Phone* ☐*Work Phone* ☐*Email*

Email _____

Your email address is needed to send you copies of any lab work and for direct communication with the doctor.

Emergency Contact _____ Phone (_____) _____-_____

Relationship to patient: ☐ Spouse ☐ Parent ☐Child ☐Other _____

How were you referred to our office?_____

Who is your primary care physician? _____ Address_____

Pharmacy_____Address_____

Put your feet in our hands"

JAMES F DONOVAN, D.P.M.
JAYSON K CHOI, D.P.M.

104 Commons Way, Building A
Toms River, NJ 08755

PATIENT INFORMATION SHEET

Medical History:

Height _____'_____" Weight _____ Last known blood pressure _____/_____ Shoe size _____

Do you have or have you ever been treated for:

☐**Diabetes**	☐Heart Attack	☐Arthritis	☐Epilepsy	☐Stomach Ulcer	☐Anemia
☐Osteoporosis	☐Fibromyalgia	☐Liver Disease	☐High Cholesterol	☐High Blood Pressure	☐Cancer
☐Blood Clots/DVT	☐Stroke	☐Hepatitis	☐Arrhythmia	☐Poor Circulation	☐Sciatica
☐Hearing Disorder	☐AIDS/HIV	☐Valvular Heart Disease	☐Kidney Disease	☐Depression	☐Gout
☐Hypothyroid	☐Hyperthyroid	☐Asthma	☐Lung Disease	☐Other Psychiatric Disorder	☐ GERD
☐Nerve Disorder	☐Alzheimer's	☐Rheumatoid Arthritis	☐Pacemaker	☐ Alcoholism/drug dependency	
☐Glaucoma	☐Other _____		☐Other _____	sobriety date: _____	

Allergies to Medications: _____

Currently taking medications: ☐ No ☐ Yes

PLEASE PRINT YOUR MEDICATIONS CLEARLY ***If you have a list, we'll make a photocopy***

Current Medications:

Name_____ strength_____ Name_____strength_____
Name_____ strength_____ Name_____strength_____
Name_____ strength_____ Name_____strength_____
Name_____ strength_____ Name_____strength_____

Family history:

☐ Diabetes (*Relationship:* _____) ☐ Heart Disease (*Relationship:* _____)
☐ Blood Clots (*Relationship:* _____) ☐ Stroke (*Relationship:* _____)
☐ Poor Circulation (*Relationship:* _____ _)

Social History: Tobacco use: ☐ Never ☐ Former (quit date:_____) ☐ Current _____ Amount daily

Drink Alcohol Daily: ☐ No ☐ Yes _____ Amount daily (# of drinks)

Past surgical history: _____

X_____ _____

Signature of patient **Today's Date**

_____

PRINT NAME OF PATIENT

"Put your feet in our hands"

ALL PATIENTS:

I authorize the release of information including my diagnosis and records of treatment rendered to me to my third party payers and to other health practitioners. **If I have not paid the doctor directly, I authorize my insurance benefits to be sent directly to Dr. James F. Donovan.**

I understand that my insurance carrier may pay less than the actual charge for services rendered. I agree to be responsible for the amount that is not paid by my insurance carrier for all services rendered on my behalf.

Financial arrangements: Payment is due when services are rendered unless other arrangements have been made in advance.

I understand that any balance remaining after my insurance carrier pays its share is due within thirty days. I understand that it is my responsibility to pay for any claims that are denied by my insurance for any reason. It is my responsibility to pay for amounts applied to deductibles, copayments, or coinsurance. Any balances that are over thirty days past due are subject to late charges of 10% of the amount due plus interest charges of 18% annually.

Checks returned from the bank, for any reason, are subject to a $30.00 handling fee.

X_____ _____

Signature of patient **Today's Date**

H I P P A (Health Insurance Patient's Privacy Act)

Please list the names people you permit us to share your medical information with

(And information concerning your appointments and bills)

_____

_____

_____

I have read and I understand the HIPPA rules concerning the health insurance portability and accountability act.

X_____ _____

Signature of patient **Today's Date**