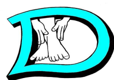


"Put your feet in our hands"



**James F. Donovan DPM**
**Donovan Family Foot Center**
104 Commons Way, Building A
Toms River, NJ 08755

# NEW PATIENT INFORMATION SHEET (under 18)

Last Name________________________________First Name__________________________Middle Initial________

**Sex** ☐Male ☐Female **Birth Date** _________/_________/_____________

Address: ______________________________________________________________Apt:_______________

________________________________________ ___________ ________________
City State Zip

Home Phone (_________) __________-_______________ Cell Phone (_________) __________-_______________

**How were you referred to our office?**_____________________________________________________________

**Medical History**:

Weight ________Height ________ Last known blood pressure ______/______ Shoe size __________

**Does patient have or ever been treated for:**

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

*PLEASE PRINT CLEARLY**

**Current Medications:** Name______________________strength_______ Name______________________strength_______
*If you have a list,* Name______________________strength_______ Name______________________strength_______
*we'll make a photocopy* Name______________________strength_______ Name______________________strength_______

**Allergies to Medications:** ______________________________________________________________

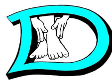
**Past surgical history:** ______________________________________________________________

Primary care physician? ________________________________ Address____________________________________

Pharmacy __________________________________________Address____________________________________

**Family history:** ☐ Diabetes (*Relationship:* ___________) ☐ Heart Disease (*Relationship:* ___________)
☐ Blood Clots (*Relationship:* ___________) ☐ Stroke (*Relationship:* ___________)
☐ Poor Circulation (*Relationship:* ___________)

**Social History:** Tobacco use: ☐Former ☐Current ☐Never Drink Alcohol Daily? ☐Yes ☐No _____Amount


"Put your feet in our hands"



**Dr. James F. Donovan**

**Donovan Family Foot Center**
104 Commons Way, Building A
Toms River, NJ 08755

# NEW PATIENT INFORMATION SHEET (under 18)

## Responsible party Contact Person:

**Responsible party:** Last Name ________________________________ First Name __________________________

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

Address: ____________________________________________________________________________Apt:_____________

___________________________________________________________ __________ _________________
City State Zip

Home Phone (_________) __________-_________________ Cell Phone (_________) __________-_________________

**Email** : _____________________________________________@______________________

*Your email address is very important to us. It is needed to send copies of any lab work and for direct communication with the doctors. Thank you!*

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

## Please fill out the following information for the person who has the insurance coverage:

Last Name of Insured: _____________________________________ First Name _________________________________

Date of Birth ________/_______/____________ Social Security Number ______________-___________-________________

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

Insured employed by __________________________________________ ☐Full time ☐Part-time ☐Retired

**Signature X** ____________________________________________________________**Date** ________________

**(Parent or Legal Guardian must sign)**

___________________________________________________ __________________________________

**Print name of parent or legal guardian** **Print name of patient**

## 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 (Donovan Family Foot Center).**

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 or the behalf of my dependents.

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

**Signature**

**x**_______________________________________________________________Date_____________

**(Parent or Legal Guardian must sign)**