



"Put your feet in our hands"

**Donovan Family Foot Center**

**James F. Donovan DPM**

**Jayson K. Choi DPM**

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:**

- |   |                                       |   |   |   |  |
|---|---------------------------------------|---|---|---|--|
| <input type="checkbox"/> GERD             | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Stomach Ulcer        | <input type="checkbox"/> Anemia          |
| <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Gout             | <input type="checkbox"/> Stroke       | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Arrhythmia       | <input type="checkbox"/> Poor Circulation     | <input type="checkbox"/> Sciatica        |
| <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> AIDS/HIV     | <input type="checkbox"/> Valvular Heart Disease | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Blood Clots/DVT |
| <input type="checkbox"/> Hypothyroid      | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Lung Disease     | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> <b>Diabetes</b> |
| <input type="checkbox"/> Nerve Disorder   | <input type="checkbox"/> Alzheimer's  | <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Other _____          |  |

*PLEASE PRINT CLEARLY\**

**Current Medications:** Name \_\_\_\_\_ strength \_\_\_\_\_ Name \_\_\_\_\_ strength \_\_\_\_\_  
*If you have a list, we'll make a photocopy* Name \_\_\_\_\_ strength \_\_\_\_\_ Name \_\_\_\_\_ strength \_\_\_\_\_  
 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



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**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



*"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 (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)**