ADULT & CHILD FOOTCARE, LLC

10 KETTLECREEK ROAD
TOMS RIVER, NJ 08753
732-255-7070
732-255-9364 FAX

PT# ________________ DATE ____________

LAST NAME ______________________ FIRST NAME________________ MI ______

ADDRESS ____________________ CITY ____________________ STATE _____ ZIP _____

HOME PHONE ______________ WORK ________________ SS# ______________________

SEX M F BIRTHDATE ___-___-___ HT: _______ WT:_____ SHOE SZ _____ WIDTH___

NAME OF INSURANCE CO _________________ NAME OF CARDHOLDER_______________

RELATIONSHIP TO PATIENT _____________ CARDHOLDER'S SS#____________________

CARDHOLDER'S BIRTHDATE (IF DIFFERENT FROM PATIENT) ____________________

WHO REFERRED YOU TO THIS OFFICE? ____

FAMILY PHYSICIAN ____

REASON FOR YOUR VISIT ____

1. ARE YOU NOW OR HAVE YOU BEEN UNDER A PHYSICIAN'S CARE DURING THE PAST 2 YEARS? IF YES, PLEASE STATE WHY____

2. ARE YOU SUBJECT TO PROLONGED BLEEDING? EXPLAIN _______________________

3. DO YOU HAVE A HISTORY OF DIABETES? _________ GOUT _______ CANCER ______

   ARTHRITIS ________ HEART CONDITION _________ ALLERGY __________________

4. HAVE YOU EVER EXPERIENCED ANY SIDE EFFECTS FROM ANY MEDICATIONS ?____

   NOVACAINE? _______ PENICILLIN _________ ANTIBIOTICS ______ OTHER _______

5. HAVE YOU EVER BEEN TREATED FOR HEART TROUBLE? _________ ASTHMA?______

   EPILEPSY?______ RHEUMATIC FEVER? ______ KIDNEY PROBLEMS______LIVER___

6. WHAT MEDICATIONS ARE YOU PRESENTLY TAKING?___________________________

7. HAVE YOU HAD ANY SERIOUS ILLNESSES OR SURGERIES?DESCRIBE______________

____

I HEREBY GIVE PERMISSION TO DR. WILLIAM A. SACHS/AND OR DR JOHN G. MCMAHON, JR. TO ADMINISTER TREATMENT;AND TO PERFORM SUCH MONOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM. I AUTHORIZE PAYMENT OF BENEFITS TO ADULT AND CHILD FOOTCARE,LLC AS AGREED UPON AT THE TIME OF TREATMENT FOR SERVICES RENDERED. I ASSUME RESPONSIBILITY FOR PAYMENT OF MY ACCOUNT.

SIGNATURE ____ DATE ________________