Biebel & DeCotiis Podiatry Associates

Podiatric Medicine Foot & Ankle Surgery

721 North Beers Street
Holmdel, NJ 07733
Telephone 732-888-1717
Fax 732-888-2101

PATIENT REGISTRATION FORM

Patient:____ SS#:____________________
Last Name First Name MI

Home Phone:______________ Cell #:________________ Work#:__________________

Address:________________________________ City:______________________________

State:________ Zip:________________ E-Mail:______________________________

Gender: M____ F____ Birthday:______________ Marital Status: S__ M__ W __D __Sep __CU__

Emergency Contact:________________________ Contact phone#:______________________

Relationship to patient:____________________

*Race______________ *Ethnicity__________ *Primary Language____________________
*(Disclaimer, Government requires this information, you may choose not to answer)

Patient's Employer:__________________________ Occupation:______________________

Primary Insurance:________________________ Responsible Party:____________________

Relationship to Patient:______________________ Date of Birth:______________________

Secondary Insurance:______________________ Responsible Party:____________________

Relationship to Patient:______________________ Date of Birth:______________________

How were you referred to our office?____

Primary Care Doctor:________________________ Phone#:__________________________

ALL CHARGES ARE PAYABLE AT THE TIME OF SERVICE. CHARGES FOR PROFESSIONAL SERVICES ARE THE RESPONSIBLILITY OF THE PATIENT REGARDLESS OF INSURANCE COVERAGE. DELINQUENT ACCOUNTS MAY BE SENT TO A THIRD PARTY FOR COLLECTION PURPOSES.

I HEREBY AUTHORIZE PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED TO BE SENT DIRECTLY TO DR. MARK BIEBEL/DR. MARK DECOTIIS/DR. GINA LAGNESE /DR. DEMETRIOS GROSSOS IF PAYMENT IS NOT MADE AT TIME OF SERVICE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY CONCERNING MY TREATMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE COMPANY. I ALSO CONSENT TO PODIATRIC TREATMENT BY DR. BIEBEL/DR. DECOTIIS OR DR. LAGNESE/DR. GROSSOS.

"ACCOUNTS 30 DAYS PAST DUE WILL BE CONSIDERED IN DEFAULT AND IT MAY BECOME NECESSARY TO REFER YOUR ACCOUNT TO AN ATTORNEY FOR COLLECTIONS. IF YOUR ACCOUNT IS REFERRED TO AN ATTORNEY FOR COLLECTIONS, THE PATIENT AND/OR RESPONSIBLE PARTY IS RESPONSIBLE TO PAY ALL AMOUNTS, INCLUDING ATTRONEY'S FEES IN THE AMOUNT OF THIRTY (30) PERCENT OF THE DEFAULT AMOUNT PLACED FOR COLLECTIONS. THE ATTORNEY'S FEES IN THE ABOVE AMOUNT SHALL BECOME DUE AND OWING AT THE TIME THE ACCOUNT IS PLACED FOR COLLECTIONS AND MAY BE ASSESSED AND ADDED TO THE BALANCE DUE AT THAT TIME REGARDLESS WHETHER THAT AMOUNT IS ACTUALLY COLLECTED"

SIGNATURE:____ DATE:____________________
RESPONSIBLE PARTY

PATIENT MEDICAL INFORMATION

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITION?
PLEASE **CIRCLE** IF YES.

DIABETES	ANEMIA	GLAUCOMA
HEART DISEASE	BLEEDING PROBLEMS	VENEREAL DISEASE
HIGH BLOOD PRESSURE	SICKLE CELL	HEPATITIS
STROKE	PHLEBITIS	LIVER DISEASE
RHEUMATIC FEVER	ASTHMA	KIDNEY DISEASE
HEART MURMUR	TB	ULCERS
ARTHRITIS	SEIZURES	STOMACH PROBLEMS
GOUT	CANCER	PREGNANT NOW?
ABNORMAL SCARS		

OTHER: ______________________________

MEDICATIONS YOU ARE TAKING NOW: ______________________________

____

ARE YOU **ALLERGIC** OR **SENSITIVE** TO ANY OF THE FOLLOWING?

ASPIRIN	PENICILLIN	ANTIBIOTICS	NOVOCAINE	IODINE
MOTRIN	CORTISONE	TAPE	OTHERS: ____________	

FAMILY DOCTOR: ______________________ CITY: ______________

PHARMACY: ________________ CITY: ____________ PHONE: __________

DESCRIBE/LIST ANY SURGERY YOU HAVE UNDERGONE: ______________

____

____

DESCRIBE YOUR FOOT OR ANKLE PROBLEM: ______________________

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Dr. Mark A. Biebel, F.A.C.F.A.S.*
Diplomate, American Board Foot and Ankle Surgery

Dr. Mark A. DeCotiis, F.A.C.F.A.S.*
Diplomate, American Board Foot and Ankle Surgery

Dr. Gina M. Lagnese, F.A.C.F.A.S.*
Diplomate, American Board Foot and Ankle Surgery

Dr. Demetrios J. Grossos
Foot & Ankle Surgery

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative clinical staff to disclose the following protected health information to:

- ☐ Myself only
- ☐ My spouse, significant other or parent (specify name) ______________________
- ☐ Other (specify name) ______________________

Information to be disclosed:

- ☐ Laboratory results
- ☐ X-Ray results
- ☐ Diagnosis
- ☐ Medications
- ☐ Immunizations
- ☐ Other test results (specify) ______________
- ☐ Other ______________
- ☐ Dates of service ______________

This protected health information is being used or disclosed for the following purposes:

- ☐ At the request of myself
- ☐ Other ______________

I would like to be contacted at my:

- ☐ Home phone: ______________
- ☐ Cell phone: ______________
- ☐ Other: ______________
- ☐ Work phone: ______________
- ☐ Mail

Regarding the office staff or physician leaving information or confirming appointments on my answering machine, voice mail or with my answering service?

- ☐ Yes, I give my permission for medical information to be left on my answering systems.
- ☐ No, I do not want messages or medical information left on my answering systems.

This authorization shall be in force and effect until revoked at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the above address. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Rule or state law. I acknowledge that a copy of Dr. Biebel's/Dr. DeCotiis'/Dr. Lagnese's /Dr. Grossos' Notice of Privacy Practices has been provided to me.

______________________ Signature of Patient or Personal Representative

______________________ Date

______________________ Print Name of Patient or Personal Representative

______________________ Description of Personal Representative's Authority

MEMBER*

American College of Foot and Ankle Surgeons

Podiatric Physicians Providing Comprehensive Care

Rev. 08/27/15