150 S Main Rd
Vineland, NJ
08360

WELCOME To

The Foot Care Centers

Rodmehr Ajdari,DPM, Tedman Tan, DPM Foroudi Farhad, DPM

500 Front Street
Elmer, NJ 08318

23 Crestview Dr
Somers Point, NJ
08244

Date______________________

Patient Information

Patient Name ____
Last Name First Name Middle Initial

Address____
____ -____
City State 9 digit Zip Code
(located on driver's license)

Best Number to reach you ____ Home ____ Cell

Home Phone (________) __________________ Cell Phone (____) ______________

Birth date ____________________ Age ________ Child Adult Male Female
Month Day Year Please Circle One Please Circle One

Social Security Number ________-_________-_______ Single Married Divorced Other
Please Circle One

Email address ____

Employer Information

Employer Name ____

Address ____
____

Phone ________________________________ Occupation ____________________________

Spouse/Parent/Guardian Information

Name ____
Last First Relationship to Patient

Date of Birth ________________________ Social Security # _____-______-_______
Month Day Year

Employer ____

Employer Phone __________________________ Occupation ______________________

Emergency Contact Information

Contact # 1

Name ____

Phone Number _____________________________ Relation to Patient ______________________

Contact # 2

Name ____

Phone Number _____________________________ Relation to Patient ______________________

Insurance Information Please Present All Insurance Cards **Date**___________

Primary Insurance

Name of Insurance ____

Identification Number ______________________________ Group Number ____________________

Policy Holder - Who is the insurance through? Relationship to Patient ____________________

Policy Holder's Name ____

Policy Holder's Date of Birth Policy Holder's Social Security Number

_______ /_________/________ _________-__________-_________

mm dd yyyy

Referral Required YES NO (Please circle one)

Secondary Insurance

Name of Insurance____

Identification Number ______________________________ Group Number ____________________

Policy Holder - Who is the insurance through? Relationship to Patient _____________________

Policy Holder's Name ____

Policy Holder's Date of Birth Policy Holder's Social Security Number

_______ /_________/________ _________-__________-__________

mm dd yyyy

Referral Required YES NO (Please circle one)

Primary Care Physician

Doctor's Name ________________________________Phone Number __________________

Address ____

____

Pharmacy you use ________________________________ Phone ____________________

Why did you choose our office?

Friend___ Yellow Pages ___ Ins. Book ___ Health fair ___ Other____________

Name: ____

Address: ____

Which Dr told you to consult us? ____

SIGNATURE REQUEST FOR INSURANCE BILLING

Release: I hereby authorize the release of any information acquired in the course of my examination which said insurance company may request.

Responsibility & Assignment: I also assign and request payment of medical benefits to the above stated physician or supplier for medical services. I also understand that I am financially responsible for payment of my bill.

X____

As a courtesy we will bill your insurance company.

Foot Care Centers

Office Policies

Thank you for choosing the Foot Care Centers. We will strive to give you the excellent professional care you deserve as our patient and friend.

We want to make your experience at the Foot Care Centers a pleasurable one. Please be aware of the procedures and policies of this office as stated below. Should you have any questions or do not understand something, please ask one of our staff members.

Co-Payments

All co-payments will be collected at the time of check-in. Your insurance company requires that you pay your co-pay at the time of your visit. Patients who fail to do this are in direct violation of their contract with their insurance company.

If you are unable to pay your co-pay at the time of your visit, we will need to reschedule your appointment.

Referrals

Patients will be advised if a referral is required for their next schedule visit. It is the responsibility of the patient to obtain this referral from their primary care physician prior to the visit. If you do not have your referral with you at the time of check-in, we will need to reschedule your appointment.

Foot Care Center is not permitted to call your primary care physician to obtain a referral for you.

Cancellation Policy

If you are unable to keep your appointment, you must call to cancel at least one full business day prior to your scheduled appointment time. Any patient who does not show up for their appointment or cancel with in the specified time frame will be billed for an office visit.

____ __________________

Patient Signature Date

FOOT CARE CENTERS

150 S. Main Rd

Vineland, NJ 08360

856-691-2152

According to New Jersey insurance company guidelines, these questions must be answered.

(Please Circle)

Do you have an Advance Directives/Living Will? (For patients 18 and above)…………YES NO

How much do you smoke?…………………………………………… ________________ N/A

How much Alcohol do you drink?…………………………………… ________________ N/A

Frequency _______________

Do you use illegal drugs?…………………………………..………………………YES NO

Do you have the following barriers that would prevent your care? (Please Circle)

Poor Vision Poor Hearing

Language Barrier Religious/Cultural Barriers

None of the Above Other _____________________

____ ___________________

Patient Signature Date

Foot Care Centers

150 S. Main Rd
Vineland, NJ 08360
(856) 691-2152

500 Front Street
Elmer, NJ 08318
(856) 358-8661

Rodmehr Ajdari, DPM Michael Monter,DPM Christopher Garbowski,DPM Tedman Tan,DPM

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or has the opportunity to read if I so choose) and understood the Notice.

________________________________ ____________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

I authorize Foot Care Centers/ Affiliated Podiatrists of South Jersey, to obtain any protected health information from health care professionals who are involved in my care.

____
Initials