New Jersey Foot and Ankle Specialists, LLC

Theodore Roberto DPM

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PATIENT PERSONAL INFORMATION

FULL NAME: _____

PERFERRED NICKNAME: _____

DATE OF BIRTH: _____ BEST PHONE NUMBER: _____

ADDRESS/STREET_____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY CARE PHYSICIAN: _____ DATE LAST SEEN: _____

OCCUPATION: _____ GENDER: _____

EMAIL ADDRESS:_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

PHARMACY: _____

_____

HOW DID YOU HEAR ABOUT US? (FRIEND? CURRENT PATIENT? WEBSITE? FAMILY?)

By signing below, I acknowledge that:

- The doctor, associate doctor and staff of the medical practice noted on this form and hereafter referred to as DOCTOR, are authorized to treat the patient named on this form
- DOCTOR is authorized to collect, use and exchange Individually Identifiable Health Information consisting of the patient's past, present and future medical information and personal information to treat patient, communicate with patients' other health care providers, seek payment, carry out necessary business functions, and mandated government reporting requirements. These situations and others, as well as your rights regarding this information are explained in our separate Notice of Privacy Practices provided for you.
- I have received a copy and have acknowledged both the HIPPA and financial compliance policies for this office.

  Signature: _____Date: _____

*If patient is under 18 years of age or unable to consent on their own behalf for whatever reason, responsible party must sign (parent/guardian/POA or other Guarantor)

Specializing in Wound Healing, Limb Preservation and Reconstructive Surgery of the Foot and Ankle