John P. Branwell, D.P.M., C.Ped.
37 Seeley Avenue
Kearny, NJ 07032
Phone: (201) 998-9700

DATE:_____

Last Name_____**First Name**_____**MI** _____

How did you hear about us? (Please circle) Internet? , Your Doctor? - If so Doctor's name?_____

Friend/Family? If so, who?_____Other reason?- Please specify _____

History of Present Illness

(Use other side of page if necessary)
What specific problem brings you to our office today?

_____

_____

Where is the pain/condition located? _____

How long ago did this problem first start? _____

How would you describe the nature of your pain? □Sharp □Dull □ Aching □Burning □Radiating

□Itching □Stabbing □Throbbing □Soreness □Other

_____

How would you rate your pain on a scale from 0 to 10 if 10 were the worst?

○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

What seems to make the pain/condition feel worse? □Walking □Standing □Resting □Dress Shoes
□ Flat Shoes □Any Closed Shoes □Daily Activities □Exercise.

_____

What makes condition feel better? _____

Have you been treated by any other physicians for this condition. If so, what was done for you?

_____

Did you have X-rays or any other tests performed related to this problem? ○ Yes ○ No

If yes where did you have the X-rays/testing performed?_____

Is this problem the result of an injury? ○ Yes ○ No If yes, is it work related? ○ Yes ○ No

What do you do for exercise? _____

REVIEW OF SYSTEMS: Are you **NOW** experiencing any of the following?

Constitutional
Appetite Loss □ Yes □ No
Weight Loss/Gain □ Yes □ No
Fever/Chills □ Yes □ No
Nausea/Vomiting □ Yes □ No

Cardiovascular
Chest Pain □ Yes □ No
Heart Disease □ Yes □ No
Varicose Veins □ Yes □ No
Cool Extremities □ Yes □ No
Hypertension □ Yes □ No
Hair Loss Legs □ Yes □ No
Leg pain when walking □ Yes □ No

Psychiatric
Anxiety □ Yes □ No
Depression □ Yes □ No
Memory Loss □ Yes □ No

Endocrine
Diabetes □ Yes □ No
Fatigue □ Yes □ No
Excess Thirst □ Yes □ No
Heat/Cold Intolerant □ Yes □ No
Excess Urination □ Yes □ No

Genitourinary
Burning or Painful Urination □ Yes □ No
Kidney Stones □ Yes □ No
Dialysis □ Yes □ No
Kidney Disease □ Yes □ No

Ear/Nose/Mouth/Throat
Nose Bleeds □ Yes □ No
Sinus Problems □ Yes □ No
Hearing Loss □ Yes □ No
Difficulty Swallowing □ Yes □ No
Sore Throat □ Yes □ No

Gastrointestinal
Abdominal Pain □ Yes □ No
Hepatitis □ Yes □ No
GERD/Heartburn □ Yes □ No
Ulcer of GI Track □ Yes □ No
GI or Rectal Bleeding □ Yes □ No

Skin
Athletes Foot □ Yes □ No
Ingrown Nails □ Yes □ No
Rash □ Yes □ No
Corns/Callus □ Yes □ No
Lumps □ Yes □ No
Ulcers/Wounds □ Yes □ No
Fungal Nails □ Yes □ No
Mole Changes □ Yes □ No
Warts □ Yes □ No

Hematological
Blood Clots □ Yes □ No
Phlebitis □ Yes □ No

Eyes
Blurred/Double Vision □ Yes □ No
Eye Disease or Injury □ Yes □ No
Wear Glasses/Contacts □ Yes □ No

Respiratory
Difficulty Breathing □ Yes □ No
TB □ Yes □ No
Lung Disease □ Yes □ No
Shortness of Breath □ Yes □ No

Musculoskeletal
Arthritis □ Yes □ No
Gout □ Yes □ No
Back Pain □ Yes □ No
Joint Pain □ Yes □ No
Cramps Leg/Feet □ Yes □ No

Neurological
Burning/Tingling/ Numbness □ Yes □ No
Stroke/TIA □ Yes □ No
Chemotherapy □ Yes □ No
Speech Disorder □ Yes □ No

Allergic/Immunologic
Hives □ Yes □ No
Itchy/Watery Eyes □ Yes □ No
Sneezing/Runny Nose □ Yes □ No

Please list any conditions that you have been diagnosed with:
1._____
2._____
3._____
4._____
5._____
6._____

Allergies: □ None Known □Adhesive Tape □Aspirin □Cephalosporins □Codeine □ Erythromycin □Flu Shot □Iodine □Latex □Lidocaine □NSAIDS □Penicillin □Quinolones □Sulfa Drugs □Tetracycline □Other medications (Please list) _____

Medications you are currently taking (Including prescriptions, over-the-counter meds and herbal supplements): **(If you have a printed list, we can photocopy it for you)**

NAME

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

FAMILY HISTORY: Do you have a <u>FAMILY</u> history of any of the following?

Psoriasis Y N? If yes who in your family?_____
Rheumatoid Arthritis Y N ? If yes, who in your family?_____
Cancer Y N ? If yes, who in your family? _____
Diabetes Y N ? If yes, who in your family? _____
Gout Y N ? If yes, who in your family?_____
Heart Disease Y N ? If yes, who in your family? _____
High blood pressure Y N ? If yes, who in your family? _____
Multiple Sclerosis (MS) Y N ? If yes, who in your family? _____
Peripheral Neuropathy Y N ? If yes, who in your family? _____
Poor Circulation Y N ? If yes, who in your family? _____
Stroke Y N ? If yes, who in your family? _____

PAST MEDICAL HISTORY: Have <u>YOU</u> ever had any of the following <u>IN THE PAST</u>?

Peripheral Neuropathy	Y N	HIV	Y N	Blood Clot	Y N
Arthritis	Y N	Kidney Disease	Y N	Cancer	Y N
Heart Disease	Y N	Dialysis	Y N	Fibromyalgia	Y N
Dementia	Y N	Ulcer Foot	Y N	Hepatitis	Y N
Gout	Y N	Acid Reflux (GERD)	Y N	Pneumonia	Y N
High Blood Pressure	Y N	Back Problem	Y N	Thyroid Disease	Y N
Polio	Y N	COPD	Y N		
Ulcer (GI)	Y N	Diabetes	Y N		
Sickle Cell	Y N	Migraine	Y N		
Asthma	Y N	Heart Attack	Y N		
Congestive Heart Failure	Y N	TB	Y N		
Dermatitis	Y N	Anemia	Y N		

<u>Women Only:</u> Are you pregnant? Y N Are you nursing? Y N

<u>Social History:</u>

Do you smoke? □ Yes □ No If yes, what type/frequency? _____
If you don't smoke now, did you ever smoke? □ Yes □ No. If yes, when did you quit? _____
Do you drink alcohol? □ Yes □ No If yes, how much? _____
Do you use or have used recreational drugs? □ Yes □ No If yes, what type/frequency? _____

Please List All Prior Surgeries/Hospitalizations:

Why?	Date	Why?	Date
1_____		4_____	
2_____		5_____	
3_____		6_____	

Patient Information:

First Name_____MI_____Last Name _____

Date of Birth_____Sex: □ Male □ Female

Race: □ Amer Indian □Asian □ Black/African American □ Hisp/Latino □ Hawaiian/Pacific □White

Ethnic group: □ Hispanic/Latino □ Not Hispanic/Latino

Preferred Language _____

Social Security #:_____

Address _____

Apt #_____City_____State_____Zip Code _____

Marital Status □ Single/never married □ Married □ Partnered □ Widowed □ Separated □ Divorced

Are you Employed: □Yes □No □Student □Retired □Child □Other

Employer Name_____Employer Phone #_____

Occupation_____

Home Phone:_____Work Phone_____Cell Phone _____

What phone number do you prefer we use?: □ Home □Work □Cell

Email address_____. Is it acceptable for us to email/text you? □Yes □No

Emergency Contact: First Name_____Last Name_____

Relationship to Patient:_____

Emergency Contact Phone Number: _____

Are you a Diabetic?: □Yes □No (Associations)

Doctor who manages your diabetes:_____Date last seen:_____

Primary Physician Name:_____Date last seen:_____

Pharmacy Name:_____Address_____

City_____State_____Zip_____Pharmacy Phone_____

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Insurance information:

Please provide us with a copy of your insurance cards and photo identification.

Does your insurance policy require a referral? □ Yes □ No
Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co._____
Group#_____
Subscriber's Name_____
Birthdate_____SS#_____
Is patient covered by additional insurance? □Yes □No
Insurance Co._____
Group#_____
Subscriber's Name_____
Birthdate_____SS#_____

INSURANCE ASSIGNEMENT AND RELEASE

1) By signing below, I certify that I have insurance coverage with the above named insurance company and I assign directly to Dr. John P. Branwell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
   The above-named doctor may use my health care information and may disclose such information to the above-named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

(MEDICARE/MEDIGAP AUTHORIZATION (For those patients that have Medicare/Medigap)

2) By signing below, I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. John P. Branwell for any services furnished tome by that provider.
   To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

3) By signing below, I certify that to the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____ _____
Print Name of Patient, Parent or Guardian Signature of Patient, Parent or Guardian Date

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize John P. Branwell, D.P.M., C.Ped. to view my external prescription history \via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at John P. Branwell, D.P.M., C.Ped., and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my John P. Branwell, D.P.M., C.Ped. medical record.

Understanding all of the above, I hereby provide informed consent John P. Branwell, D.P.M., C.Ped. to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain in force until revoked or changed.

Patient Name (PLEASE PRINT)_____

Signature_____ Date_____

Office Financial Policy

1) On arrival, please sign in at the front desk and present your current insurance card and photo ID at every visit. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit
2) Payment is expected at the time of service. This includes co-payments or coinsurance for participating insurance companies. John P. Branwell, D.P.M., C.Ped. accepts cash, personal checks, VISA, MasterCard and Discover Card.
3) Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
4) As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. It is your responsibility to be sure your referral is current.
5) Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
6) All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
7) There is a service fee of $25.00 for all returned checks.
8) If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. If you do not call a $25.00 fee may be charged.

Please call if you have a question about your bill. Most problems can be settled easily and your call will prevent misunderstandings. If you are having trouble paying your bill, please tell us as satisfactory arrangements can almost always be made. Financial concerns should never prevent you or your family member from receiving the care they need.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Date:_____

Patient Name: _____

If minor name of responsible party: _____

Signature:_____