Date:____________________________

Patriot J. Caputo, DPM **2020** **Douglas DeLorenzo, DPM**

Welcome to our Board Certified Podiatric Office
Caputo Foot & Ankle Centers: Holmdel Foot & Ankle Center & Holmdel Wound Care Center, LLC

Name: ______________________________ ______________________________ ________ **S.S. #:** (*** - ** -_________)
(Last) (First) (Middle)

Address: ____ ____________________________ ________
(Street) (City, State, Zip) (Years There)

Preferred Phone Contact: ___________________________ **Secondary Phone:** ___________________________
Circle One → Home Cell Work Circle One → Home Cell Work

May we leave on message on your answering machine? Circle one: Yes / No

Birthdate: _____/_____/_____ **Age:** _______ **Marital Status:** Single / Married / Divorced / Separated / Widowed / Other: ____________

Employer/School: ________________________________ **Occupation:** ______________________ **How Long:** ________

Emergency Contact: ____ **Phone:** ________-_______-___________

E-mail: ____

PHARMACY: ________________________________ **City:** ___________________________ **PHONE:** ________-________-__________

IMPORTANT! -- Subscriber/Policy Holder Insurance Information: (ONLY if different from patient)

Name: _________________________________ ***Birthdate:*** ___/____/____ ***Relationship To Patient:*** ____________________

Employer: _____________________________ ***Occupation:*** ______________________________ ***How Long:*** ___________

Family Physician – Dr.: ____ **Phone:** _______-_______-_________

Please Describe Your Foot/Ankle Problems: ____

Patient Authorization:

- I request that payment of authorized Medicare or Insurance benefits be made either to me or on my behalf to Dr. Patrick J. Caputo (or any physician of Caputo Foot & Ankle Centers), for all services provided to me by these physicians or suppliers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or my insurance, its agents, any information needed to determine these benefits or the benefits payable for related services.
- **I authorize my insurance benefits be paid directly to the Doctor's Office.**
- **I am financially responsible for any deductible, co-insurance & non-covered services. All co-paymentes are due at time of service.**
- I give permission to the Doctor to examine and begin management and perform such general procedures, as he/she may deem necessary in the diagnosis and/or treatment of my condition.
- I understand that there are no guarantees associated with any working diagnosis or treatment.
- **Cancellation Policy**: **We understand that there are times that you may need to cancel an appointment. Please do so within a 24 hr. period. For repeat offenders a nominal charge may be applied.**
- Notice of Privacy Practices is available in the Waiting Room and copies available upon request.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS:

Signature: ____ Date: ________________

Please Turn Page Over

Name: ____ Date:______________

A. Please **CHECK** and/or **CIRCLE** all that pertain to ***YOUR Medical History***:

______ Diabetes (Glucose=_________A1c=_______)
______ High Blood Pressure (Good control: Yes / No)
______ Heart Disease, Stroke or on Blood Thinners
______ Poor Circulation or Prior Vascular Surgery
______ Neuropathy, Burning or Pins & Needles
______ Wound Care Problems/Slow healing wounds
Y / N Did you ever have a MRSA Infection?
______ Anemia, Blood Disease, or Blood Clots
______ Thyroid Condition
______ Psoriasis
______ Toenail Problems or Severe Athlete's Foot

Y / N Are you a Current Smoker?
Y / N If Prior Smoker; Quit when?______________
Shoe Size:______ & Common style: _____________
Height:________ Weight: ____________________

_____ Kidney Infection or Stones
_____ Poor functioning Kidney, Renal Failure, or Dialysis
_____Liver Disease, Cirrhosis, Fatty Liver or Hepatitis,
_____Stomach Ulcer or Gastritis/Hiatal Hernia
_____Emphysema/COPD/Recent Pneumonia
_____Asthma (what causes it):____________________________
_____Arthritis (what joints): ____________________________
_____ Gout (When was last attack):________________________
_____Fracture: Ankle/Foot or Severe Ankle Sprain
_____Severe back problems
_____Hip or Knee Joint Replacement
_____Balance Problems, Unsteady Walking, or Recent Fall
_____Anxiety, Depression, Seizures, or Nervous System Disorder
_____ Cancer:____
_____Skin Cancer (Part of Body): __________________________
_____(Other)____

*****VERY IMPORTANT*****

B. CURRENT PRESCRIPTION MEDICATIONS (and OTC Meds) *Check if you brought Rx List (______)*

1) Rx__________________________ for_____________
2) Rx__________________________ for_____________
3) Rx__________________________ for_____________
4) Rx__________________________ for_____________
5) Rx__________________________ for_____________
6) Rx__________________________ for_____________

* Other Vitamins, Minerals and OTC Products ____

C. Please list ALLERGIES and describe Allergic REACTION *Check if you brought Allergy List (______)*

Allergy 1:____________________________ Reaction: _______________________________________
Allergy 2: ____________________________ Reaction: _______________________________________
Allergy 3: ____________________________ Reaction: _______________________________________
Allergy 4: ____________________________ Reaction: _______________________________________

D. HOSPITALIZATIONS and SURGERIES within past 10 years, or Any Minor Foot/Ankle Surgery or Injury

- ____ _____________ Year ______
- ____ _____________ Year ______
- ____ _____________ Year ______

E. How did you find out about Drs. Caputo/or Associates? Please check **all** that apply! Thank You.

Referred from Family Physician or Office Staff: Dr. ____
Referred from Other Doctor/Nurse/Therapist (name): _____________________________________
Referred from Friend/Relative (name): ____
Insurance List: ______ Hospital/Wound Care Center Referral: ______ Recognized the name/Good reputation: ___________
Website/Google/Internet: ______ Social Media/Facebook: ______ Yellow pages: ______ Other:________________
Have you or has anyone in your family been treated in our office before? YES / NO
If yes, NAME? ____

Office use:
Reviewed By_____

CAPUTO FOOT & ANKLE CENTER

HOLMDEL WOUND CARE CENTER, LLC

Patrick J. Caputo, DPM, FASPS and **Douglas DeLorenzo, DPM, FACFAS**
Board Certified in Foot Surgery: American Board of Foot & Ankle Surgeons
Wound Care & Sports Medicine Specialists

719 N. Beers St., Ste. 2A
Holmdel, NJ 07733

www.HolmdelFootAndAnkle.com
www.HolmdelWoundCare.com

Phone: (732) 739-3230
Fax: (732) 739-4656

Date:_______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND PATIENT POLICIES AND PROCEDURES

I hereby acknowledge that I have received, read and had an opportunity to ask questions concerning the above names practice's **Notice of Privacy Practice Policies and Procedures.**

The above named practice may discuss my treatment with the following people (include any family, friends or other contacts):

NAME	PHONE NUMBER	RELATION TO PATIENT

I may be contacted at the following locations:

_____Y _____ N Home Ph#_________________________

_____Y _____ N Cell Ph# _________________________

_____Y _____ N Other Ph# _________________________

May we leave a message regarding our medical care/test results on our answering machine?
_____Y _____ N

Print Patient's Name: ____

Sign here: X____
Patient or Patient's Representative Signature

If signed by representative, state name of representative: ____

Relationship to Patient: ____