ERIC ROCKMORE, DPM, FACFAS

www.nervepainnj.com

Date: _______________

Name____ Date of Birth____________________

Address____City____________________State___________Zip Code_________

Email Address__________________________________ Preferred Language____

Social Security(Medicaid only)______________ Referred by____

Gender_______________ Race_____________________ Ethnicity___________________

Home# (_____) ___________________ Work # (_____)_____________________ Cell (_____)_______________________

Preferred phone # (_____)______________________ Permission to Call Work # ____ Yes ____No

Primary Care Physician & Address ____Phone# (_____)_____________

Employer & Address____

Occupation____ Indicate if Student____________________________________

Emergency Contact_______________________________ Relationship ___________________ Phone # (____)___________

◊◊

Insurance Information

Primary Carrier_______________________________ ID #________________________ Group #_____________________

Name of Subscriber ____Relationship to Subscriber __Self __Spouse __Parent

Subscribers Employer____________________________________ Subscriber's DOB______________ SS #_________________

Secondary Carrier ____________________________ID #_________________________ Group # _____________________

Subscriber_____________________ Relation to Patient __________Subscriber's DOB _________ SS#________________

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ASSIGNMENT AND RELEASE

I hereby authorize payment from my insurance company for services rendered to be sent directly to Dr. Eric Rockmore. If payment is not made at the time of the service, I authorize the release of medical or incidental information to my insurance company concerning my treatment. Further, by affixing my signature below, I assign Dr. Eric Rockmore the right to appeal insurance claims on my behalf. I certify that the attached information given by me is correct. I understand that I am responsible to comply with my insurance company's policy and procedures and are responsible for any amount not covered by insurance, this may include services denied or deemed non-covered by my insurance company.

Signature____ Date_________________________________

2/2013

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MEDICAL HISTORY

Name_____ **Date**_____

Medications_____

_____

Surgery
Date_____ Procedure_____

Pharmacy Name & Phone #_____

( ) **I am not allergic to anything to my knowledge**
( ) **I am allergic to**: _____**Type of Reaction**____

Have you ever been diagnosed or treated for the following:

___Anemia
___Kidney Problems
___Arthritis
___Asthma
___Bleeding Disorder
___Cancer/Type_____
___convulsions/Epilepsy
___Depression
___Diabetes
___Gout
___Heart Disease Type_____
___Heart Attack
___Hepatitis A, B, C
___High/Low Blood Pressure
___PAD
___Neuropathy
___HIV
___Phlebitis/DVT/Blood clots
___Sleep Apnea
___Stomach Ulcer
___Stroke
___High Cholesterol
___Hypothyroid

Other Medical Conditions_____

Family History of: ___Diabetes ___Heart Disease ___Other _____

Social History: Alcohol: ___Yes ___No ___Quit When_____

Tobacco: ___Yes ___No ___Quit When_____

Substance abuse: ___Yes, Type_____ ___No

Height_____ Weight _____ Shoe size_____

Patient signature_____ Date_____

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PLEASE CIRCLE RESPONSE FOR EACH ITEM BELOW

CONSTITUTIONAL SYSTEMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred vision or double vision	No	Yes
Glaucoma	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina	No	Yes
Palpitations	No	Yes
Shortness of breath while Walking/lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Muscle pain or cramps	No	Yes
Back Pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

PSYCHIATRIC

Memory loss/confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE

Glandular or hormone problems	No	Yes
Thyroid disease	No	Yes
Excessive thirst or urination	No	Yes
Heat/cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat/glove size	No	Yes

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes

INTEGUMENTARY (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes

NEUROLOGICAL

Frequent/recurring headaches	No	Yes
Light headed/dizziness	No	Yes
Convulsions/seizures	No	Yes
Numbness/tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

RESPIRATORY

Sleep apnea	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

Patient signature_____

Date_____

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MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Eric Rockmore for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signature_____ Date_____

PRIVACY NOTICE

Our practice is committed to securing the privacy of your health information. Accordingly, we have a copy of our practices Notice of Privacy in the reception area. You are required to read this Notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Signature_____ Date_____

** We reserve the right that any requests for medical records must be in writing**

I authorize Dr. Eric Rockmore to release information regarding my medical condition to the following:

NAME AND ADDRESS	PHONE #	RELATION TO PATIENT

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Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions please discuss them with our office manager.

As our patient, you are responsible for all referrals needed to seek treatment in this office.

We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay / co-insurance / deductible at the time of service. There is a 5.00 rebilling fee if the copay is not paid at the time of service. Your insurance company does not cover this fee.

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. If we send you a bill, payment is due within 30 days.

Accounts with unpaid balances greater than 30 days are subject to a rebilling fee of 15.00 each month and are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office

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; however, patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

There is a 30.00 service fee for all returned checks. Your insurance company does not cover this fee.

There is a 50.00 charge for all missed appointments that were not cancelled 24 hours before the appointment. The first missed appointment is forgiven.

_____

Signature of Responsible Party

_____ _____

Print Name Date

Disclosure: Dr. Rockmore is a founding member and 2% owner of the New Jersey Surgery Center, LLC

1/2013