Chart Number _____

Dr. Sharmila Jani
Chatham Podiatry Center
54 - 56 Center Street
Chatham, NJ 07928
(973) 635 - 0593

Welcome to our office.

Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ SSN _____ DOB _____

Mobile Phone (____) _____ Email Address _____

Employer _____ Work Phone (____) _____ Ext____

Insurance Co _____

Policy # _____ Group # _____

Insured's Name _____ Relation _____

Secondary Insurance Co _____ Policy # _____

Insured's Name _____ Relation _____

Ethnicity _____

Hispanic/Non Hispanic (circle) Preferred Language _____

What is your main occupation? _____

Does this occupation keep you on your feet? (full time, part time) _____

What is your present foot problem? _____

Have you previously been treated for foot issues? _____

When/Where? _____

Who may we thank for referring you? _____

Personal Physician _____ Town _____

Smoker/Nonsmoker (circle) How many cigarettes do you smoke a day? _____

CONTINUED ON OTHER SIDE

Allergies: Please explain any adverse reactions you have had to any medications.

_____

_____

Please explain any food or environmental allergies and reactions.

_____

_____

Please list any active medications that you take, including dosages.

_____

_____

List the types and dates of your surgical history.

_____

_____

Circle any that you have or have ever had:

Diabetes (insulin dependent/non – circle) Cancer Heart Disease/Heart Attack

Arthritis (degenerative/rheumatoid – circle) Asthma/Breathing Problems

High Blood Pressure High Cholestorol Stroke CHF Gout

Poor Circulation/Cold Feet Phlebitis/Varicose Veins Stomach Disorders

Nerve Disorders Muscle Disorders Mental Disorders/Substance Abuse

Other Pysical Conditions_____

Height _____ Weight _____ Shoe Size _____

AUTHORIZATION.

I have requested that Dr. Sharmila Jani will accept assignment from Medicare or my authorized, private insurance carrier. I understand that I am responsible for any deductibles, co-insurance, and non-covered services. I understand that not all podiatric services may be covered under my plan. In the event that my insurance company does not cover benefits for billed services, I understand that I am responsible for payment. I understand that if I do not have insurance or if Dr. Sharmila Jani does not accept my insurance, payment will be my responsibility at the completion of the visit.

Please sign here_____