

OFFICE USE ONLY: LAST SEEN \_\_\_\_\_

NEW PATIENT \_\_\_\_\_ UPDATED \_\_\_\_\_ REFERRAL \_\_\_\_\_

DR PHILIP OBIEDZINSKI www.DrOonline.com

PATIENT'S INFORMATION

Page 1 of 6

Patient's name. \_\_\_\_\_

Address \_\_\_\_\_ APT. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(PHOTO ID REQUIRED IF POST OFFICE BOX)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

EMAIL \_\_\_\_\_

(necessary for portal access & appointment reminders)

Home Phone# \_\_\_\_\_  Work \_\_\_\_\_ Ext. \_\_\_\_\_

Cell Phone# \_\_\_\_\_ (Please check off preferred calling #)

Working \_\_\_\_\_ Retired \_\_\_\_\_ Other \_\_\_\_\_ Child \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Your signature on this form authorizes us to use this signature on file for all commercial & Medicare insurance. It authorizes Dr. Obiedzinski to release and request any and all medical information needed to provide services to me.

**Medicare patients: Your signature here means you have not received the same treatment in the last 61 days. If you did Medicare will not pay and you will receive a bill from our office. (this does not apply to New patients).**

**MEDICAID PATIENTS: WE DO NOT TAKE MEDICAID AND WILL NOT BE ABLE TO SEE YOU, PLEASE CONTACT YOUR INSURANCE COMPANY FOR A PARTICIPATING PROVIDER.**

IF YOU WOULD LIKE A COPY OF OUR PRIVACY RULES PLEASE ASK AT THE FRONT DESK. A COPY WILL BE PROVIDED TO YOU OR YOU CAN GET THEM FROM OUR WEBSITE: www.DrOonline.com

Date \_\_\_\_\_ Signature PATIENT/PARENT/GUARDIAN: \_\_\_\_\_  
(must be 18 or over) (PLEASE SIGN)

## Insurance and HIPAA information

### Primary insurance

(please list the name of the person the policy belongs to) **Self** **Spouse** **Partner** **Child**

Name of person \_\_\_\_\_ Date of Birth \_\_\_\_\_

(if address is different) \_\_\_\_\_

### Secondary Insurance

(please list the name of the person the policy belongs to) **Self** **Spouse** **Partner** **Child**

Name of person \_\_\_\_\_ Date of Birth \_\_\_\_\_

(if address is different) \_\_\_\_\_

### Tertiary Insurance

(please list the name of the person the policy belongs to) **Self** **Spouse** **Partner** **Child**

Name of person \_\_\_\_\_ Date of Birth \_\_\_\_\_

(if address is different) \_\_\_\_\_

### ***In case of an EMERGENCY who can we contact?***

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship: \_\_\_\_\_

Do you want the above-mentioned person to have access to your records? (circle): Yes No

***We will not speak to any one unless you have listed them above. IF YOU  
WOULD LIKE A COPY OF OUR PRIVACY NOTICE PLEASE LET US KNOW.***

# Philip J. Obiedzinski, D.P.M., P.A.

## *Diplomate American Board of Foot and Ankle Surgery*

*Board Certified in Foot and Ankle Surgery*

*Hackensack University Medical Center –Senior Attending – Department of Podiatry*

*50 Orient Way – Rutherford, NJ 07070-2036*

*201 939-2774 Fax 877-453-7229 Email: [droonline@hotmail.com](mailto:droonline@hotmail.com) Website: [DROonline.com](http://DROonline.com)*

## Patients Responsibility

We accept credit cards and cash for 1<sup>st</sup> time patients.

Our office tries to be respectful of your time and we try to not over-book. We would appreciate if you need to cancel that you give us 24 hours notice. We reserve the right to charge \$25.00 for a missed appointment.

Patient/Parent/Guardians responsibility to have valid insurance card, referral (if necessary) and co-pay at the time of the visit.

If a referral is required by your insurance company, you are expected to have one at the time of the visit. If you are unable to do so, please reschedule your appointment. Referrals can be faxed to our office at the above-mentioned fax #.

Our office has a secured Portal for you to use. Please give us your email for secured communications for copies of your records, lab results, prescription renewals and making appointments.

It is our office policy that to receive **a paper copy** of your chart, we must have the request in writing. Please provide the name, date of birth and a phone number, should we need to call you. Paper copies are \$1.00 per page and will require 3 days notice. Payment must be made before we will print. We will contact you with the amount and you can pay using a credit card. We can fax paperwork to a doctor's office within three business days at no additional cost.

The office will do their best to obtain the preauthorization for procedures and medications if required by insurance but we do not guarantee the positive outcome in all cases since different insurance plans have their own rules that we would not be able to change. We can not be responsible for any incorrect information your insurance company gives out. Should you want to appeal any decision by your insurance company we will be happy to assist you.

Any verbal or physical expression of aggression towards office staff or Doctor is cause for immediate discharge from the practice.

*A copy of this document is available upon request.*

\_\_\_\_\_  
(Patient/Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

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## Billing policy changes as of Sept 1<sup>st</sup>, 2017

### Our expectations of you:

1. If your specific medical plan denies payment for a covered service,
2. (ex. Deductible, co-insurance, etc.) you/guarantor, are responsible for the fees your insurance company failed to pay.
3. Copays are due at the time of service.
4. Should there be a change in your copay and it was not apparent at the time of service you will be responsible for the remainder.
5. Realize that insurance policies restrict payment for some services, use restricted fee schedules, and exclude some procedures. All restrictions are based on the contract between the insurance company, your employer and you.
6. Should you receive a check from your medical insurance it is your responsibility to pay this to our office. **Please deposit the check and send us your check in the amount. Make a copy of the explanation of benefits and send it to us with your payment.**
7. We understand that your deductible can be a large one. Our billing procedure is as follows:
  - You will receive an initial billing from our office and payment is due upon receipt.
  - If you need to work out a payment plan, please DO NOT HESITATE to call our office we will be willing to work with you.
  - 30 days you will receive a second bill with a notice that Non-negotiable fee of \$12.50 will be added to your bill if not received in 14 days
  - 45 days the Non-negotiable fee will be added to your bill.
  - 60 days you will receive a final notice and our collection department will take it from there.

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(Patient/Guardian) signature

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Date

FEVERS  
WEAKNESS  
WEIGHT CHANGES  
DIZZINESS  
HEADACHES  
MIGRAINES  
BLOODY NOSE  
SINUS PROBLEMS  
DENTURES  
HEARING PROBLEMS  
TROUBLE SWALLOWING  
PERSISTENT COUGH  
ASTHMA  
SHORTNESS OF BREATH  
EMPHYSEMA  
PALPITATIONS  
HIGH BLOOD PRESSURE  
SWELLING OF LEGS  
HEART MURMUR  
EXTREMITY DISCOLORED  
CARDIAC A FIB  
CARDIAC MI  
HEART FAILURE  
ANEURYSM  
THROMBOSIS  
EMBOLISM (PULMUNARY)  
CHEST PAIN  
ANKLE SWELLING  
FOOT SWELLING  
CARDIAC PACEMAKER  
DEFIBRILLATOR  
RHEUMATIC FEVER  
VOMITING  
HEPATITIS  
HEARTBURN/GERG  
RECTAL BLEEDING  
NAUSEA  
HERNIA  
GERD  
STOMACH ULCER  
LEG CRAMPS  
ARTHRITIS  
GOUT  
JOINT STIFFNESS  
JOINT PAIN

BACK PROBLEMS  
CALF PAIN  
ARTHRITIS RHEUMATOID  
PHLEBITIS  
OSTEO ARTHRITIS  
SPINAL STENOSIS  
SCIATICA  
HERNIATED/BULG DISC BACK  
HERNIATED DISC (NECK)  
BULGING DISC (NECK)  
PSYCHIATRIC DISABILITY  
ALZHEIMERS  
EASY BRUISING  
CHRONIC SKIN RASH  
NEUROPATHY  
TREMORS/PARKINSON'S  
SEIZURES/ EPILEPSY  
MEMORY LOSS  
STROKE/MINI STROKE  
THYROID DISEASE  
URINE FREQUENT  
ANEMIA  
TRANSFUSION REACTIONS  
BLEEDING EASILY  
SEASONAL ALLERGIES  
VD  
URINE BLOODY  
BLADDER UREGENCY  
BLADDER STONES  
KIDNEY STONES  
KIDNEY DISEASE  
VISION LOSE  
CATARACTS  
EXCESSIVE TEARING  
GLAUCOMA  
BLURRED VISION  
DOUBLE VISION  
SENSITIVE TO LIGHT  
DO YOU WEAR GLASSES  
BLINDNESS PARTIAL  
MACULAR DEGENERATION  
DRY EYE  
**SMOKING - EVERYDAY**  
**SMOKING - SOME**  
**FORMER**

NEVER  
MORE THAN SOCIAL DRINKING YES  
NO

### FAMILY HISTORY

HYPERTENSION	MOM	DAD
HYPERLIPIDEMIA	MOM	DAD
HEART DISEASE	MOM	DAD
DIABETES TYPE 1	MOM	DAD
DIABETES TYPE 2	MOM	DAD
COPD	MOM	DAD
THYROID DISEASE	MOM	DAD
BREAST CANCER	MOM	DAD
COLORECTAL CANCER	MOM	DAD
OTHER CANCER	MOM	DAD
ALCOHOLISM	MOM	DAD
BUNIONS	MOM	DAD
FOOT PROBLEMS	MOM	DAD
HEEL PAIN	MOM	DAD
HAMMER TOES	MOM	DAD
GOUT	MOM	DAD
MENTAL ILLNESS	MOM	DAD
OTHER		
ADOPTED		

LIST ANY MEDICAL CONDITION NOT MENTIONED ☐

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LIST ALL SURGERIES ☐

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PLEASE LIST ALL MEDICATIONS ☐

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PLEASE LIST ALL **MEDICATION** ALLERGIES & REACTIONS : (ex. Latex, tape, Iodine) ☐

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LIST ANY FOOD ALLERGIES & REACTIONS ☐

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FEMALE PATIENTS: ARE YOU CURRENTLY PREGNANT?

NO                      YES    Due Date \_\_\_\_\_

Complete if you know

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_