JAMES RICKETTI, D.P.M. BRANDON BOSQUE, D.P.M.

PATIENT # **TODAY'S DATE**

PATIENT INFORMATION SHEET
(PLEASE COMPLETE ALL APPLICABLE INFORMATION)

LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
HOME# _____ CELL# _____ WORK# _____
DOB _____ AGE _____ GENDER _____ SOCIAL SECURITY # _____-_____-_____
EMAIL ADDRESS_____ OCCUPATION _____

MARITAL STATUS _____ STUDENT _____
EMPLOYMENT: FULL-TIME PART-TIME UNEMPLOYED
EMPLOYER _____
ADDRESS _____ CITY/STATE _____ ZIP _____

RESPONSIBLE PARTY (OF OTHER THAN PATIENT): PARENT / SPOUSE / OTHER
LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
PHONE # _____

PRIMARY CARE PHYSICIAN _____ REFERRAL _____
ADDRESS _____ CITY/STATE _____ ZIP _____
PHONE# _____ LAST SEEN _____

PRIMARY INSURANCE (PLEASE PROVIDE INFORMATION & COPY OF CARD):
INSURANCE COMPANY NAME _____
POLICY # _____ GROUP # _____
SPECIALIST COPAY AMOUNT $_____

SUBSCRIBER (IF OTHER THAN PATIENT): PARENT / SPOUSE / OTHER
LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
DOB _____ PHONE # _____

SECONDARY INSURANCE:
INSURANCE COMPANY NAME _____
POLICY # _____ GROUP # _____
SPECIALIST COPAY AMOUNT $_____

SUBSCRIBER (IF OTHER THAN PATIENT): PARENT / SPOUSE / OTHER
LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
DOB _____ PHONE # _____

MOTOR VEHICLE ACCIDENT _____ WORKER'S COMP _____ OTHER _____
DATE OF ACCIDENT _____ CLAIM # _____(WE MUST HAVE BEFORE SEEN)
INSURANCE CO. TO BE BILLED _____
CLAIMS ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE # _____ FAX# _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I (print) _____ understand the Notice of Privacy for the office.

Yes _____ I choose to receive a copy of this notice.

_____

Signature Date

EMERGENCY CONTACT INFO

NAME: _____
HOME # _____ CELL# _____
WORK # _____
RELATIONSHIP _____

PHARMACY NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE # _____

I AUTHORIZE THE EXCHANGE OF MEDICAL AND INSURANCE INFORMATION TO OTHER PHYSICIANS AS NECESSARY FOR MY TREATMENT, CARE AND INSURANCE PROCESSING.

I AUTHORIZE THE RELEASE FO ANY INFORMATION NECESSARY TO MY INSURANCE CARRIERS FOR THE PROCESSING OF MY MEDICAL CLAIMS FOR PAYMENT TO ME OR JAMES C. RICKETTI, D.P.M.

I AGREE TO PAY APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE!!!!

SIGNATURE _____ DATE _____

JAMES C. RICKETTI, D.P.M.
BOARD CERTIFIED
DIPLOMATE OF AMERICAN BOARD OF
PODIATRIC MEDICINE

BRANDON BOSQUE, D.P.M.

Acct # _____

2020

Surcharge Fee for Credit Cards Payments

Acknowledgement of the 2% Surcharge on all transactions.
Visa/MC/AMEX/Discover Cards
(There will be no Surcharge applied to HSA cards)

Signature_____Date_____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT RECEIPT

I (print)_____have received

a copy of this office's **Notice of Privacy Practices.**

Signature_____Date_____

I allow my Medical information to be released to :

1)Name_____Relationship_____

Phone number_____

2)Name_____Relationship_____

Phone number_____

Foot Specialist/Surgeon/Sports Medicine/Wound Care
Golden Crest Corp. Center
2275 State Highway 33, Suite 204
Hamilton Sq., N.J. 08690

(609) 587-1674 Fax# (609) 587-2206