Dr. Daniel Hennessy, DPM
3155 State Route 10 Suite 215
Denville NJ, 07834
973-895-3288

Demographic Information

Last: _____ First: _____ MI: _____

Date of Birth: _____/_____/_____(mm/dd/yy) Sex: _____ Race: _____

Social Security #: _____/_____/_____ Ethnicity: _____

Address: _____ Line 2: _____

City: _____ State: _____ Zip: _____

How did you hear about our practice? _____

Contact Information

Cell: (_____) - _____ - _____ Email: _____

Home: (_____) - _____ - _____ Work: (_____) - _____ - _____ Ext: _____

Emergency Contact Information

Last: _____ First: _____ MI: _____

Address: _____ Line 2: _____

City: _____ State: _____ Zip: _____

Home: (_____) - _____ - _____ Cell: (_____) - _____ - _____

Primary Care Physician

Name: _____ Name of Practice: _____

Address: _____ Phone: (_____) - _____ - _____

City: _____ State: _____ Zip: _____

Pharmacy Name: _____ Phone: (_____) - _____ - _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

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Authorization to release or use information for treatment, payment, or health care operations

I, hereby authorize the release and/or use of the individually identifiable health information (protected health information or PHI) and medical information by Denville Foot and Ankle in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.
We reserve the right to change the terms of this Notice of Privacy Practices at any time. If we do make any change to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.
You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

Payment/Charges
Payment is due at time of service. You will be responsible for paying any co-payments, co-insurance, deductibles, non-covered services, or supplies at the time of service. We accept Cash, Check, Debit/Credit Card. Services will be filed to your insurance

I agree and consent to releasing information to me in the following manners:

Via Mail

Via Home Telephone

Via Cellphone

Via Work Telephone

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** ____/____/_____

DENVILLE
FOOT & ANKLE

No Show Policy

Our goal is to provide quality medical care to all our patients in a timely manner. In order to be able to accommodate other patients with appointments, we request that you please notify the office 24 hours in advance to reschedule or cancel if you are not able to keep your appointment.

Our no-show Policy is as follows:

- A 24-hour notice is required to reschedule or cancel your appointment.
- Late cancellations such as calling last minute before your scheduled appointment will be considered as "No Show".
- **First No Show Appointment:** You will receive a courtesy phone call to remind you of the missed appointment and you have the possibility to reschedule at that time.
- **Second No Show Appointment:** You will receive your second courtesy phone call to remind you of the missed appointment as well as remind you if it occurs a third time you will be charged.
- **Third No Show Appointment:** You will receive a phone call from our office letting you know this was your third No Show for our office. You, NOT your insurance company, will be charged $50.00 for the time slot we were not able to fill when you were a No Show.
- **Four or more No Show Appointments:** A phone call will not be made by our office. You will be responsible for a $50.00 charge anytime you are a No Show from this point on.

I _____, have reviewed the above No Show policy and fully understand my responsibility as a patient to Denville Foot and Ankle.

Signature_____ Date_____

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Patient Communication Form

Please describe your complaint(s) (Be as detailed as possible):

How long has this problem(s) been present?

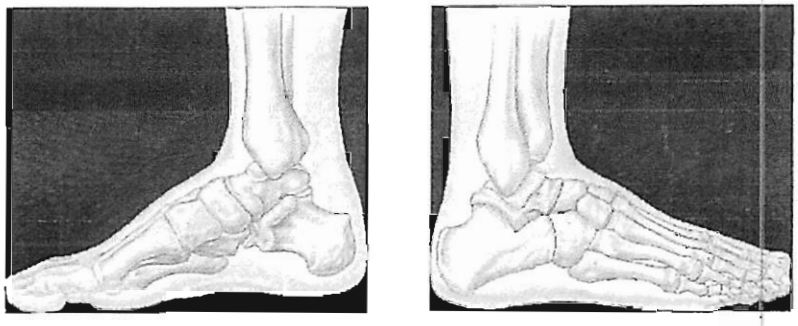
What specific incident started this complaint(s)?

What treatment(s) have you tried previously?

Please indicate on the diagram the area(s) involved:

Right Foot

Left Foot



Swelling

Pain (1 – 10)

Discoloration

Name of Primary Care Physician:

Last Visited: _____/_____/_____

Have you ever been to a podiatrist before? If yes, please list name(s) and date of visit:

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Medical History

Height:___ ft. ___ in. Weight: _____lbs. Shoe Size: _____

Diabetes: Yes No
High blood pressure: Yes No

Do you smoke? Yes No

- If yes, for how long?
- If no, have you smoked in the past?
    - If yes, when did you quit?

Do you drink alcohol? Yes No

- If yes, how many glasses per day do you drink?
- What type of alcohol do you drink? (ex: wine, beer, hard liquor)

Please list all medical conditions:

Please list all current medications (both prescription and non-prescription):

Please list ALL allergies:

List any previous surgeries: