



Dr. Daniel G. Hennessy

Dr. Jade S. Richard

3155 State Route 10 Suite 215

Denville, NJ 07834

Phone: 973-895-3288 Fax: 862-276-2018

Web: www.denvillefootandankle.com

Demographic Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Sex: _____ Race: _____

Social Security # _____ - _____ - _____

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Contact Information

Cell Phone: _____ Home Phone: _____

Email: _____

Emergency Contact Information

Last Name: _____ First Name: _____

Phone Number: _____ Relation: _____

PCP Name and Phone Number: _____

Pharmacy Name and Phone Number: _____

How did you hear about us? _____

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Welcome and thank you for choosing our Medical practice for your healthcare needs. In our effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read out Financial Policy, fill out the demographic and health history forms for your medical file.

If at any time you have a question regarding our office policies do not hesitate to contact us and we will be happy to help you. Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and a provider for most PPO and HMO plans in your area. It is your responsibility to make sure we are in your insurance plan. If your insurance requires a referral or prior authorization, it is your responsibility to make sure that it is in place prior to your appointment. We will be glad to assist you if you need help.

We will bill your insurance company as a courtesy to you. All co-payments are due at the time of your visit. If you have an unmet deductible, we pre-collect 50% of the charges incurred that your insurance will apply towards your deductible. If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed directly to you and due at that time.

Balances/Collection Fee: If balances are not paid within 14 days from the statement date a \$30 rebilling fee will be added to each additional statement sent for the unpaid balance. A consistent attempt will be made to collect outstanding balances.

Past due accounts, more than 90 days, will be turned over to our collection department and a 35% fee of the balance due will be added to cover collection costs.

Complete payment for all soft goods, medical products and supplies are due at the time they are dispensed.

A 24 hour notice is requested for cancellations of appointments. If you fail to show for an appointment you personally may be charged a \$75 no-show fee. We will try to accommodate you in rescheduling your appointment as soon as possible.

Sign _____ Date _____

Patient Communication Form

Please describe your complaint (s):

What specific incident started this complaint (s):

How long has this problem (s) been present:

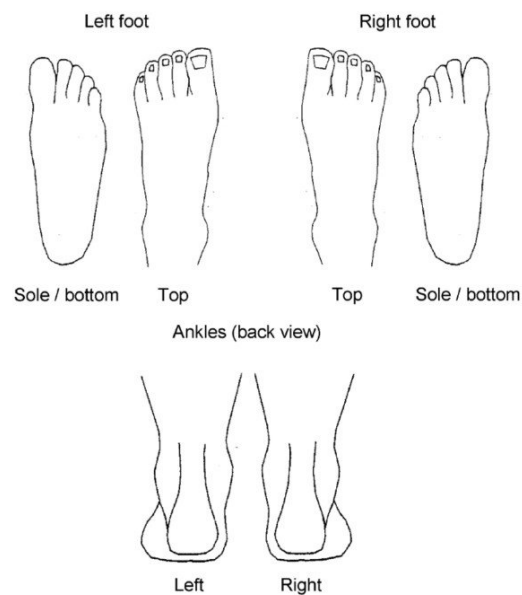
What treatment (s) have been tried previously:

Please indicate where the complaint is:

Right or Left Foot

Swelling or No Swelling

Pain on a scale of 1 to 10 _____



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Vitals

Height: ____foot ____ inches Weight:____lbs Shoe Size_____

Social History

Do you Smoke? Yes ____ No ____

 If yes, for how long?_____

Do you drink? Yes ____ No ____

 If yes. How many per week?_____

Medical History

List all Medical conditions:

List all Medications:

List all Allergies:

List all previous surgeries:

Family Medical History:

Mother:_____

Father:_____

Sister:_____

Brother:_____