Dr. Wendy Stinson
3799 US 46 East, Suite 103
Parsippany, NJ 07054
Phone: 973-382-6999 Fax: 973-381-2355
www.wendykstinsondpm.com

Thank You for Choosing Dr. Wendy Stinson, DPM!

Helpful Information Before Your Appointment:

- The attached document MUST be completed by ALL patients - both **NEW AND EXISTING** - this is a requirement of our new billing service who requires the information in this format. If it is not completed before your appointment, you will need to stay after your appointment to complete it.
- GPS Directions easiest to find us: Hilltop Plaza, Parsippany, NJ 07054
- If you are more than 15 minutes late, you **WILL NOT** be seen and will need to reschedule. There is no time to fit you into the same day.
- Bring a current list of your medications (if not placed on the paperwork)
- Bring your insurance card(s) and photo ID - Both NEW AND EXISTING patients must provide at first appointment of 2025
- Any Co-Pays or Outstanding Balance (co-insurance, deductible) are due at the time of the appointment or you will NOT be seen. Billing questions can be answered by calling 973-382-6999 x2

PLEASE BE AWARE THAT WE ARE A SMALL OFFICE, AND IT CAN TAKE UP TO 48 HOURS TO RETURN YOUR PHONE CALL.

Dr. Wendy Stinson
Diplomate, American Board of Foot & Ankle Surgery

Patient Registration Form

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Office Policies

*** Dr. Stinson does not guarantee a phone call/text to confirm your appointment. We do our best to notify you the day before, but you are ultimately responsible for knowing when your appointment is scheduled. ɛɛɛ Dr. Stinson strives to see all patients at the scheduled appointment time. If you are more than 15 minutes late, Dr. Stinson will try and fit you in if possible.
*** I grant my permission and consent to be evaluated and receive treatment from Dr. Wendy Stinson with a mutually agreed upon treatment plan for either short term or on-going treatment
*** The office utilizes text and email to communicate with patients; my signature below allows permission.

Financial Information

I authorize the release of information necessary to any entities to secure the payment of benefits submitted for services rendered by Dr. Wendy Stinson, DPM on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service to secure the payment of benefits. I further agree and acknowledge that my signature on this document authorizes claims to be submitted for benefits for any services rendered without obtaining my signature on every claim form. Should the need arise, I also authorize Dr. Wendy Stinson, DPM to file a complaint on my behalf for any dispute or appeal regarding accurate and fair reimbursement for services rendered.

I understand I am responsible for knowing if Dr. Stinson is in or out of my network for benefits. The office is happy to assist you in finding this out if you email the front and back of your insurance card to stinsoninsuranceandbilling@gmail.com as well as your date of birth. If you don't email us, we assume that you know your benefits – copays, deductible, coinsurance, etc.

I understand I am financially responsible for all charges incurred if my insurance carrier denies payment for any reason - deductible, copays, and/or coinsurance. It is my responsibility to know if my deductible has been met.

In the event my insurance carrier issues a payment directly to me, I will pay Dr. Stinson the same amount paid to me, plus any co-pays/deductibles/coinsurances due. I agree to send in a check along with the explanation of benefits upon receipt of payment within 10 business days of receipt of payment.

You must pay your in-network specialist copay OR $50 towards the deductible/coinsurance at the time of service. Any amount applied to deductible/co-insurance will be billed to you.

We impose a surcharge fee of 3% on all Credit Card Transactions. This fee is not greater than our cost of acceptance. There is no surcharge applied to Debit Cards, Zelle, Venmo, or check payments. If a personal cehck is returned, a fewwof $35 will be charged and can not be billed to insurance.

I have read, understand and agree to the above.

_____/_____/_____
Today's Date

_____
Patient's Name (Please Print)

_____
Patient's Signature

_____
Authorized Person Name and Relation to Patient

_____
Authorized Person Name Signature

Dr. Wendy Stinson
Diplomate, American Board of Foot & Ankle Surgery

Patient Registration Form

Personal Information Today's date:_____

Patient's First Name: _____ MI:____ Last Name: _____

Date of Birth: _____/_____/_____ Gender: Male / Female/ Other

Social Security #: _____-_____-_____ Marital Status: Married / Single / Divorced / Widowed

Race: White / Asian / African American / Hispanic / Latino / Pacific Islander / Native American

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino

Home Address:_____ City:_____ State:_____Zip Code _____

Employment Information

You are currently: Employed / Unemployed / Student / Retired

If you are employed, what is your occupation, if retired what is your prior occupation:

Occupation _____

Personal communication and Emergency Contact Information

Home Phone #: (_____) _____-_____ Cell Phone #:(_____) _____-_____

May we leave a message on your phone? Yes / No **If Yes**, Cell / Home / Both

Email:_____@_____._____ Fax#: (_____) _____-_____

May we send you an email, fax or text documents or messages? Yes / No

Emergency contact name:_____

Emergency contact phone #: (_____) _____-_____

Emergency contact relation: Spouse / Parent / Child / Friend / Sibling / Other_____

How were you referred to our office?

Medical Doctor / PT or Trainer/ Relative / Friend / Coworker / Google / Our Website / Insurance/ ZocDoc/Healthgrades/Social Media

Who may we thank for referring you?:_____

Are you here because of an Auto Accident or Workers Comp claim?

Is this visit due to an automobile accident: Yes / No

Is this visit due to a worker's compensation issue: Yes / No

If yes, please provide us with a copy of your insurance card, claim number and lawyer contact information

_____

Insurance and Guarantor Information - *Please provide your insurance card or cards and photo ID*

Do you have health insurance: Yes / No, If yes, please continue below.

Name of Insurance Company:_____

Insurance ID #: _____

Are you the primary policy holder? Yes / No, If No please complete below

The primary policy holder is my: Spouse / Parent / Domestic Partner

If you are **NOT** the primary policy holder, please provide the following;

Primary policy holder's full name:_____

Primary policy holder's date of birth: _____/_____/_____

Primary policy holder's address: Same as mine: Yes / No

If No, please provide address: _____

Do you have a secondary insurance: Yes / No

Name of Insurance Company:_____

Insurance ID #: _____

If Yes, are you the secondary policyholder? Yes / No, If No, please complete below,

Secondary policy holders full name:_____

Secondary policy holder's date of birth: _____/_____/_____

Secondary policy holder's address: Same as mine: Yes / No

If No, please provide insured's address:

_____

Primary Medical Doctor

Who is your Primary Medical Doctor?_____

What is their office phone number? (_____) _____-_____

Date of last visit:_____ *Medicare patients this is required

Do you see any specialists (cardiovascular, endocrinologist, etc)? YES or NO

Pharmacy Information

PHARMACY NAME: _____

PHARMACY ADDRESS (including town): _____

PHONE NUMBER: (_____) _____-_____

May we electronically request your RX history from your pharmacy? Yes / No

By signing below, I authorize Dr. Wendy Stinson, DPM to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and their office manager. It may include prescriptions back in time for several years, and may include, if applicable, prescriptions to treat HIV, substance abuse and psychiatric conditions. I understand that my prescription history will become part of my medical record. I also give permission for Dr. Wendy Stinson, DPM to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction. Patient Signature _____

Allergy Questions

Do you have any material, medication or food allergies? Yes / No

If Yes, what is your allergy? (Circle all that apply)

epinephrine / aspirin / codeine / penicillin / cortisone / iodine / sulfa / tetracycline

erythromycin / Demerol / morphine/ latex / Levaquin / Cipro/ seafood/ adhesive

Other:_____ Other:_____ Other:_____ Other:_____

Current Prescription Medication

Are you currently taking any prescription or over-the-counter medications? Yes / No

If Yes, Please complete below or bring a list in at the time of your appointment

Name of Medication	Name of Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Conditions

Do you have any medical conditions? Yes / No

If Yes, please circle all that apply, **even if you are taking medication for the condition**

Alzheimer's or memory loss	anemia	anxiety
atrial fibrillation	back problems	bleeding disorder
cancer, type_____	COPD	congestive heart failure
coronary artery disease	diabetes	GERD
glaucoma	hearing loss	heart valve problem
hearts attack or MI	heart problem	hepatitis
high cholesterol	HIV or AIDS	hypertension
kidney disease	liver disease	migraines
Parkinson's	peripheral arterial disease	peripheral neuropathy
prostate problem	psoriasis	Raynaud's
rheumatoid arthritis	seizure disorder	Gout
stroke or TIA	thyroid problem	vision problems
other_____	other_____	other_____

Surgeries

Have you had any surgeries? Yes / No (If Yes, please circle all that apply)

appendix	back	bariatric
bladder	bypass legs	bypass heart
cataract	colon	gallbladder
heart valve	kidney	liver
Organ transplant, organ_____	prostate	replacement hip
replacement knee	thyroid	vein stripping
other_____	other_____	other_____

Social and Family History

Do you currently smoke cigarettes? Yes / No

If yes, how many packs per day do you smoke? Less than 1 / 1 pack / > 1 pack per day Have you smoked in the past? Yes / No

If yes, when did you quit? This year / 1-5 years ago / More than 5 years ago

Do you drink alcohol regularly? Yes / No
If yes, how much? Socially / 1 drink per week / 1 drink per day / 1 or more per day

Family History

Disease	**Who? (parent, grandparent, or siblings)**
Diabetes	_____
Poor Circulation	_____
Amputation	_____
Cancer	_____
Heart Disease	_____
Lung Disease	_____
Gout	_____

Height: _____ **Weight:**_____ **Shoe Size:** _____

Designation Of Patient Spokesperson (PHI)

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to discuss and access my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below.

Patient Information: Please Print
Patient Name:_____ Date Of Birth:_____
Address:_____ Phone #:_____

Authorized Individual: Please Print
Name:_____ Relation To Patient:_____
Address:_____ Phone #:_____

I grant to the individual named above to have access to:
_____ All of my PHI

_____ Other- Specify limits or specific health care incident

1. I understand that I may revoke these designations at any time by notifying the appropriate Curalta Foot & Ankle Associates in **writing**; however, if I do revoke the authorization, it will not have any effect on any actions taken by Curalta Foot & Ankle Associates prior to their receipt of the revocation.
2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.
3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPPA
4. I understand that this authorization will: (Must check one)
   ( ) expire 1 year from the date executed
   OR
   ( ) be effective for the lifetime of the patient unless revoked

Signature of Patient/Personal Representative:_____

Name Of Personal Representative:_____ Date:_____

Relationship to patient:_____

YOU MAY REFUSE TO SIGN THIS FORM

Dr. Wendy K. Stinson, DPM

Diplomate, American Board of Foot & Ankle Surgery

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Parsippany, NJ 07954
(T) 973-382-6999
(F) 973-381-2355

NJ Lic: 25MD00273900
Tax ID: 01-0862272
NPI: 1053355503
E-MAIL: doctorwendystinson@gmail.com

FOOT / ANKLE/ LOWER LEG PROBLEM:

Please provide the following information on what your chief complaint is:

Today's Date: ____/____/_____

First Name: _____Last Name: _____ DOB : _____

Weight: _____ Shoe Size: _____

What type of problem are you experiencing? ____thick painful toenails ____ingrown toenail
____Infection ____Corns/Calluses _____Bunions _____hammetoes ____heel pain
Other:_____

Where is the location of this problem? (Be specific - which foot, location on foot)

_____

_____

How long have you had this problem? _____ Pain 1-10 with 10 being severe _____

How did it occur?

_____ Trauma _____ Injury _____ Gradual Onset ____ Rapid Onset _____ Pain Off/On

What are the characteristics of the pain?

Sharp		**Aching**	
Shooting		**Throbbing**	
Stinging		**Stabbing**	
Burning		**Numbness**	

If needed, provide more information regarding the pain:

_____

_____

Does anything help the pain? _____ Yes _____ No

If so, what_____

Does anything make the pain worse? _____ Yes _____ No

If so, what_____

Have you seen another physician for this problem?_____ Yes _____ No Who? _____

What treatments have you attempted for this problem?

_____