Podiatry Associates of Florida

PATIENT INFORMATION FORM

PERSONAL INFORMATION

DATE:

Full Name :

Social Security # :

Gender : ☐ Male ☐ Female

Address :

City/State : **Zip Code** :

Date of Birth : **Email Address** :

Status : ☐ Single ☐ Married ☐ Divorce ☐ Seperated ☐ Widowed

Employer/Occupation :

May we leave a message? (circle options you prefer)

Home Phone: **Email:**

Cell Phone:

EMERGENCY CONTACT DETAILS

Contact Name : **Contact Name** :

Relationship : **Relationship** :

Phone Number: **Phone Number:**

PRIMARY CARE DOCTOR

Primary Care Doctor :

Who Referred You? :

Is there a family member or other person you would like for us to share your medical information with? If yes, what is their name? If no, please leave blank.

Podiatry Associates of Florida

PATIENT INFORMATION

PAYMENT INFORMATION

WHO IS RESPONSIBLE FOR PAYMENT?

Full Name :

Relationship to Patient :

Address : _____

City/State : _____ **Zip Code** : _____

Date of Birth : _____ **Email Address** : _____

INSURANCE INFORMATION

Patient's Relationship to Insured : **Please circle one**

Self **Spouse** **Child** **Other**

Primary Insurance Company Name: _____

Address: _____

City/State: _____ **Zip:** _____

Insured Name : _____

Date of Birth : _____ **Contract #** : _____

Employer : _____ **Group #** : _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance:Company Name: _____

Address: _____

City/State: _____ **Zip:** _____

Contract # _____ **Group #** _____

Podiatry Associates of Florida

PATIENT INFORMATION

PATIENT MEDICAL INFORMATION

PATIENT NAME :

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS). NAME DOSE & HOW OFTEN YOU TAKE:

PLEASE LIST ALL PRIOR SURGERIES. TYPE OF SURGERY AND SURGERY DATE:

SOCIAL HISTORY

Please circle what applies.

USE OF ALCOHOL:

NEVER **NO LONGER USE** **HISTORY OF ALCOHOL ABUSE** **CURRENTLY USE**

CURRENT USE:

RARE **OCCASIONAL** **MODERATE** **DAILY**

Podiatry Associates of Florida

PATIENT INFORMATION

PATIENT NAME AND DATE OF BIRTH:

SOCIAL HISTORY CONT.

Please circle what applies.

USE OF TOBACCO:

NEVER QUIT (HOW LONG AGO?) _____ SMOKE _____ PACKS/DAY FOR _____ YRS

USE OF RECREATIONAL DRUGS:

NEVER QUIT (HOW LONG AGO?) _____ TYPE:_____

CURRENTLY USING TYPE:_____

HOW OFTEN? RARELY OCCASSIONALLY MODERATELY DAILY

HOW MUCH ARE YOU ON YOUR FEET AT WORK?

10% 25% 50% 75% 100%

HOW MUCH DO YOU EXERCISE?

NEVER RARELY OCCASIONALLY WEEKLY SEVERAL TIMES/WEEK DAILY

WHAT TYPE OF EXERCISE DO YOU DO?

_____

FAMILY HISTORY

Please circle what applies.

DO YOU HAVE A FAMILY HISTORY OF:

DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE STROKE

CORONARY ARTERY DISEASE THRYOID DISEASE RHEUMATOID ARTHRITIS

OTHER _____

Podiatry Associates of Florida

PATIENT INFORMATION

PATIENT NAME AND DATE OF BIRTH:

YOUR MEDICAL HISTORY

Please circle what applies.

DO YOU SUFFER FROM ALLERGIES? YES NONE KNOWN

IF YES, DO THEY INCLUDE: ANESTHESIA FOODS (WHAT TYPE) _____

TAPE LATEX SHELLFISH IODINE OTHERS (PLEASE LIST)

_____

_

HAVE YOU EVER HAD ANY OF THE FOLLOWING? **Please circle what applies.**

- ACID REFLUX
- ANEMIA
- ARTHRITIS
- ASTHMA
- BACK TROUBLE
- BLADDER INFECTIONS
- ABNORMAL BLEEDING
- BLOOD CLOTS
- BLOOD TRANSFUSION
- BRONCHITIS/EMPHYSEMA
- CANCER
- DIABETES
- FIBROMYALGIA
- GOUT
- HEART ATTACK
- HEART DISEASE/FAILURE
- HEPATITIS
- HIV/AIDS
- HIGH BLOOD PRESSURE
- KIDNEY DISEASE
- LIVER DISEASE
- LOW BLOOD PRESSURE
- MIGRAINE HEADACHES
- MITRAL VALVE PROLAPE
- NEUROPATHY
- OPEN SORES
- PNEUMONIA
- POLIO
- RHEUMATIC FEVER
- SICKLE CELL DISEASE
- SKIN DISORDER
- SLEEP APNEA
- STOMACH ULCERS
- STROKE
- THYROID DISEASE
- TUBERCULOSIS
- OTHER CONDITIONS_____

Podiatry Associates of Florida

PATIENT INFORMATION

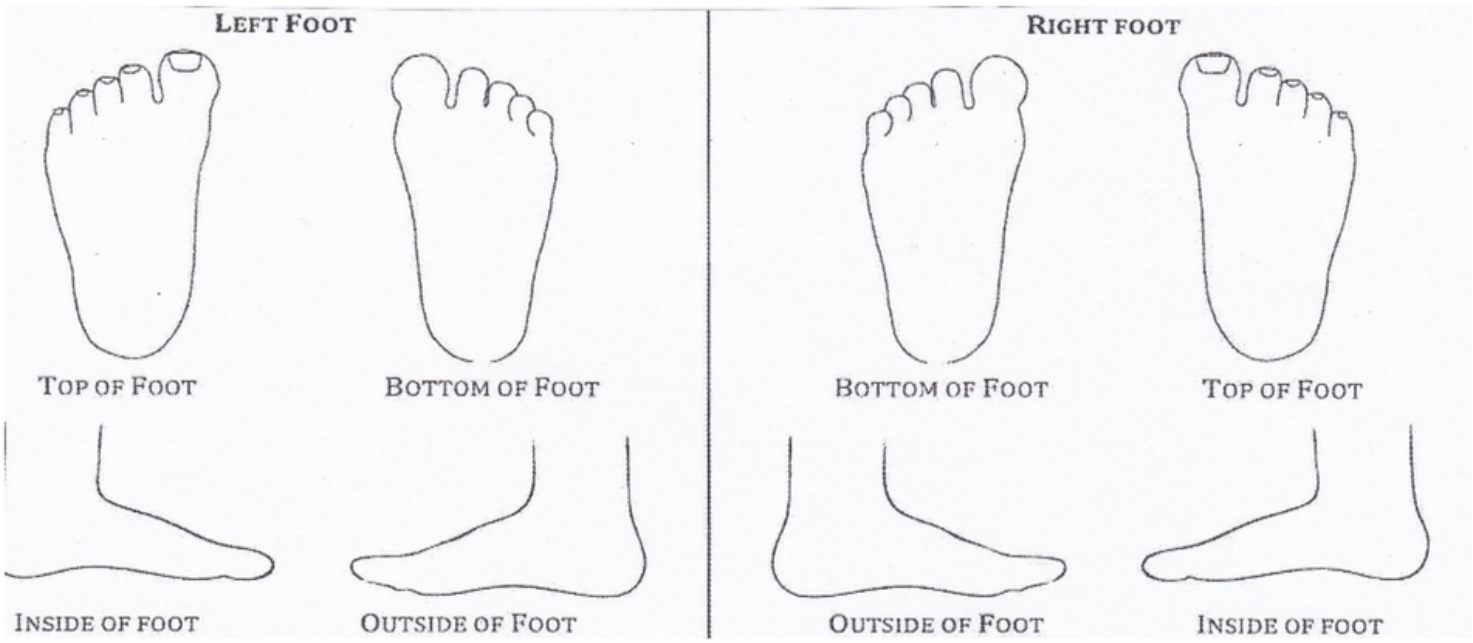
PATIENT NAME AND DATE OF BIRTH:

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

_____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK THE PICTURES BELOW.



Podiatry Associates of Florida

PATIENT INFORMATION

PATIENT NAME AND DATE OF BIRTH:

CURRENT PROBLEM

HOW LONG AGO DID THE PROBLEM FIRST START?

_____ DAYS _____ WEEKS _____ MONTHS _____ YEARS

DID YOUR PAIN OR PROBLEM: ***PLEASE CIRCLE THE ANSWER THAT APPLIES***

BEGIN ALL OF THE SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ***PLEASE CIRCLE THE ANSWERS THAT APPLY***

NO PAIN SHARP DULL ACHING BURNING RADIATING ITCHING STABBING

OTHER_____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE OF 0 TO 10? ***PLEASE CIRCLE***

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ***PLEASE CIRCLE THE ANSWER***

STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ***PLEASE CIRCLE THE ANSWERS THE APPLY***

WALKING STANDING DAILY ACTIVITIES RESTING DRESS SHOES HIGH HEELS

FLAT SHOES ANY CLOSED TOE SHOE RUNNING OTHER _____

Podiatry Associates of Florida

PATIENT INFORMATION

PATIENT NAME AND DATE OF BIRTH:

CURRENT PROBLEM

WHAT MAKES YOUR PAIN OR PROBLEM FEE BETTER?

_____

WHAT TREATMENTS HAVE YOU TRIED FOR THIS PROBLEM?

_____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

_____

WAS THIS PROBLEM CAUSED BY AN INJURY? **YES** **NO**

IF YES, PLEASE DESCRIBE? _____

WAS IT A WORK-RELATED INJURY? **YES** **NO**

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING THE INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____

IF OTHER THAN PATIENT, PRINT RELATIONSHIP TO PATIENT

_____

SIGNATURE

_____

DATE

PODIATRY ASSOCIATES OF FLORIDA, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOSE) AND UNDERSTAND THE NOTICE.

_____ _____

PATIENT NAME (please print) **DATE**

_____

PARENT OR AUTHORIZED REPRESENTATIVE (if applicable)

_____

SIGNATURE

PATIENT FINANCIAL AGREEMENT

This letter sets forth the financial payment policy for Podiatry Associates of Florida, Inc.
I understand that, as a recipient of medical care, I, the undersigned, am responsible for all charges regardless of my circumstances. Upon signing below, I acknowledge and agree that payment in full is due on the date of service. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate him for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his/her services, notwithstanding any contract I may have with a third-party payer (i.e., insurance company, employer, etc.).
I, the undersigned, do hereby authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on my behalf or my dependents behalf. Further, I expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims for services rendered, without obtaining my signature on each claim. Additionally, I will be bound by this signature as if the undersigned had personally signed the particular claim.
I hereby authorize my insurance company to pay and assign directly to Podiatry Associates of Florida, Inc., all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid will be credited to my account. All unpaid charges are my responsibility.
Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances.
Should I fail to pay outstanding charges for more than thirty (30) days, I will incur a service fee of $25. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection agency and/or attorney fees.
Should I fail to show for an appointment or give at least 24 hours' notice of cancellation, I agree to pay a fee of $25 per occurrence.
I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

1. I agree to provide Podiatry Associates of Florida, Inc., with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/ or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized
2. I will pay all applicable copays and any outstanding patient balances as they become due. Copays and any outstanding patient balance is due at each visit.
3. Deductibles are due at the time of service.
4. Surgery copays/coinsurance/deductibles are due two (2) days prior to surgery.

I give my consent to Podiatry Associates of Florida, Inc. to provide medical care and treatment, deemed necessary and proper in diagnosing or treating his/her/my physical condition, to the below named patient.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

SIGNED (patient or guarantor) _____

PRINT NAME SIGNED ABOVIE _____

Date: _____

FOR (print patient name) _____

Podiatry Associates of Florida

Dear Patient:
Medicare and other insurance companies have instituted new policies which require us to follow new guidelines. For us to fulfill these new requirements, we must ask you for additional information regardless of whether you are an established patient, or not. Please take a moment to provide us with the following information. All information you provide is confidential and is not used for any purpose other than meeting insurance company requirements.

Name: _____

Email Address: _____
Please be advised that your email address is not sold or used for marketing.

PREFERRED PHARMACY

Pharmacy Name: _____

Location: _____

Phone Number: _____

PLEASE CIRCLE:

Language: English Spanish Other: _____

Ethnicity: Asian Black Pacific Islander Hispanic Caucasian

Other:_____

Podiatry Associates of Florida