TODAY'S DATE:_____

PRIMARY PHYSICIAN:_____

REFERRED BY:_____

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME:_____ MI:____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ SEX: **M** ◯ **F** ◯

ADDRESS: _____CITY:_____

STATE: _____ ZIP CODE:_____ EMAIL:_____

CELL PH:_____ HOME PH:_____ WORK PH:_____

MARTIAL STATUS: **SINGLE / MARRIED / DIVORCED / SEPERATED / WIDOWED**

EMPLOYMENT STATUS: **EMPLOYED / STUDENT / RETIRED**

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PLAN TYPE: _____

POLICY: _____ GROUP:_____

RELATIONSHIP TO SUBSCRIBER: **SELF** ◯ **SPOUSE** ◯ **CHILD** ◯ **OTHER** ◯

SECONDARY INSURANCE: _____ PLAN TYPE: _____

POLICY: _____ GROUP:_____

RELATIONSHIP TO SUBSCRIBER: **SELF** ◯ **SPOUSE** ◯ **CHILD** ◯ **OTHER** ◯

IN CASE OF EMERGENCY

CONTACT NAME: _____ RELATIONSHIP: _____

CELL PH: _____ HOME PH: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

PARENT/GUARDIAN SIGNATURE:_____ **DATE**:_____

PATIENT MEDICAL/ SURGICAL HISTORY AND PHYSICAL QUESTIONNAIRE

PATIENT NAME:_____ TODAY'S DATE:_____
PRIMARY PHYSICIAN:_____ LAST VISIT DATE:_____

CHIEF COMPLAINT:_____
SHOE SIZE:_____ HEIGHT:_____ WEIGHT:_____

PAST MEDICAL HISTORY

___DIABETES: TYPE 1___ TYPE 2____
___ASTHMA
___POOR CIRCULATION
___VARICOSE VEINS/ VENOUS STASIS
___FOOT/ LEG ULCERS
___HEART TROUBLE
___HIGH BLOOD PRESSURE
___STROKE/ CVA/ TIA
___SCIATICA
___NERVOUSNESS/ ANXIETY
___OSTEOARTHRITIS
___RHEUMATOID ARTRITIS
___HIV/ AIDS
___HEPATITIS B
___SCLERODERMA
___BLEEDING DISORDERS
___TUBERCULOSIS
___KIDNEY DISEASE
___DIALYSIS
___STOMACH ULCERS
___ANEMIA
___LEG CRAMPS: DAY____ NIGHT____
___HEADACHES/ MIGRAINES
___CANCER TYPE
___GOUT
___DEPRESSION
___POLIO
___SCAR POORLY
___LUPUS
___BLINDNESS/ RETINOPATHY
___HEPATITIS C

ARE YOU CURRENTLY PREGNANT? _____
ARE YOU SUBJECT TO PROLONGED BLEEDING? _____
DO YOU USE TOBACCO? YES ___ NO___ CIGARETTES____ CHEW____ CIGARS____ PIPE____

SURGICAL HISTORY

1._____DATE:_____
2._____DATE:_____
3._____DATE:_____
4._____DATE:_____
5._____DATE:_____
6._____DATE:_____

OTHER HOSPITILIZATIONS

1._____DATE:_____
2._____DATE:_____
3._____DATE:_____

HAVE YOU HAD ANY INJURIES TO YOUR FEET, ANKLES, LEGS, OR BACK? YES ____ NO____

MEDICATION LIST

MEDICATION NAME:	**STRENGTH:**	**HOW OFTEN:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ I AM NOT ALLERGIC TO ANY MEDICATION THAT I AM AWARE OF.

I AM ALLEGRIC TO THE FOLLOWING:

_____ ASPIRIN
_____ CODEINE
_____ NOVOCAINE
_____ VICODIN
_____ PENICILLIN
_____ CIPRO
_____ TRANQUILIZERS
_____ CORTISONE
_____ TAPE/ ADHESIVES
_____ IODINE
_____ SULFA DRUGS
_____ ANTIHISTAMINES
_____TERACYCLINE
_____ OTHER:_____

OTHER PROBLEMS

_____ HEAD/ NECK
_____ EARS
_____ NOSE
_____THROAT
_____ LUNGS
_____ BACK
_____ INTESTINAL
_____ BLADDER
_____ BOWEL
_____ CIRCULATION
_____WEIGHT
_____ENERGY LEVEL
_____ ABILITY TO SLEEP
_____ PAIN/ DISCOMFORT

CONSENT FOR TREATMENT: I VOLUNTARILY CONSENT TO THE TENDERING OF CARE, INCLUDING TREATMENTS, ADMINISTRATION OF ANESTHESIA AND PERFORMANCE OF DIAGNOSTIC AND/ OR SURGICAL PROCEDURES. I UNDERSTAND THAT I AM UNDER THE CARE AND SUPERVISION OF THE ATTENDING PHYSICIAN AND IT IS THE RESPONSIBILTY OF THE STAFF TO CARRY OUT THE INSTRUCTIONS OF SUCH PHYSICIAN(S).

RELEASE OF INFORMATION: THE PHYSICIAN(S) MAY DISCLOSE ALL OR PART OF THE PATIENT'S RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER A CONTRACT TO THE PHYSICIAN(S) OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE PHYSCIAN(S) CHARGES, INCLUDING BUT NOT LIMITED TO, INSURANCE COMPANIES, WORKER'S COMPENSATION CARRIERS, WELLFARE FUNDS, OR THE PATIEN'TS EMPLOYER.

MEDICARE AND MEDICAID PATIENT CERTIFICATION-PATIENTS CERTIFICATION AUTHORIZATIONT TO RELEASE INFORMATION AND PAYMENT REQUEST: I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE VII AND/ OR TITLE XIX, OF THE SOCIAL SECURITY ACT, IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OF ITS INTERMEDIARY CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A MEDICARE OR MEDICAID CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN(S) SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLE AND CO-INSURANCE.

_____	_____	_____
PATIENT NAME(PRINT)	PATIENT SIGNATURE	DATE

PATIENT FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____ DATE:_____

THANK YOU FOR CHOOSING A FLORIDA FOOT AND ANKLE PHYSICIAN FOR YOUR PODIATRY NEEDS. WE ARE HONORED BY YOUR CHOICE AND ARE COMITTED TO PROVIDING YOU WITH THE BEST QUALITY OF CARE. WE ASK THAT YOU READ AND SIGN THIS FORM TO ACKNOWLEDGE YOUR UNDERSTANDING OF THE PATIENT FINANCIAL RESPONSIBILTY.

PATIENT FINANCIAL RESPONSIBILTY

- PATIENTS ARE REPSONSIBLE FOR THE PAYMENT OF **COPAYS, CO0INSURANCE, DEDUCTIBLES, AND ALL OTHER PROCEDURES OR TREATMENT** NOT COVERED BY THEIR INSURANCE PLAN AT THE TIME OF SERVICE.
- FOR YOUR CONVEINENCE, FLORIDA FOOT AND ANKLE ASSOCIATES, LLC (FFAA) WILL BILL THE PATIENT'S INSURANCE FOR SERVICES PROVIDED. HOWEVER, THE PATIENT IS REQUIRED TO PROVIDE FFAA WITH THE MOST CORRECT AND UPDATED INFORMATION ABOUT THEIR INSURANCE COVERAGE.
- THE PATIENT (OR PATIENT'S GUARDIAN, IF A MINOR) IS ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF TREATMENT AND SERVICES RENDERED BY FFAA.
- PATIENTS WILL BE RESPONSIBLE FOR THE PAYMENT OF ADDITONAL CHARGES INCURRED BUT NOT LIMITED TO THE FOLLOWING:
    1. CHARGE FOR RETURNED CHECKS
    2. ANY COSTS ASSOCIATED WITH COLLECTION OF PATIENT BALANCES
    3. CHARGE FOR MISSED APPOINTMENTS WITHOUT ADVANCE NOTICE OF AT LEAST 24 HOURS PRIOR TO APPOINTMENT.

I HAVE READ, UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS PATIENT FINANCIAL RESPONSIBILITY FORM:

_____ _____

PATIENT SIGNATURE DATE

_____

PATIENT NAME(PRINT)

POLICY ON MISSED APPOINTMENTS/CANCELLATIONS/NO SHOWS

$35.00 CHARGE FOR NO SHOWS/CANCELLATIONS

OUR FOLLOW-UP PROTOCOLS ARE BASED ON YEARS OF EXPERIENCE AND PROVIDE YOU WITH THE HIGHEST STANDARD CARE. KEEPING YOUR APPOINTMENT IS IMPORTANT TO THE HEALTH OF THE PATIENT AS WELL AS TO THE OUTCOMES OF THE TREATMENTS BEING PRESCRIBED. WHEN YOU DO NOT KEEP YOUR APPOINTMENT, WE HAVE GAPS IN OUR SCHEDULE THAT AFFECTS THE SCHEDULE FOR THE WHOLE DAY. THOSE GAPS COULD HAVE BEEN GIVEN TO OTHER PATIENTS WHO NEED SOONER APPOINTMENTS.

YOU WILL BE CONSIDERED A NO-SHOW IF YOU MISS AN APPOINTMENT AND DO NOT NOTIFY US 24 HOURS IN ADVANCE. **YOU WILL RECEIVE A BILL FOR $35.00 IF YOU NO SHOW/CANCEL OR RESCHEDULE.**

OUR OFFICE MAKES EVERY EFFORT TO REMIND YOU OF YOUR APPOINTMENT. PLEASE UPDATE YOU HOME AND CELL PHONE NUMBERS, ADDRESS AND EMAIL ADDRESS WHENEVER THERE IS A CHARGE. IF YOU DO NOT COMPLY WITH OUR POLICY AND REGULATIONS UNFORTUNATELY, WE WILL HAVE TO DISCHARGE YOU FROM OUR PRACTICE.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

_____ _____

PATIENT SIGNATURE DATE

PHARMACY INFORMATION

PHARMACY NAME:_____

PHARMACY ADDRESS:_____

PHARMACY PHONE NUMBER:_____

PATIENTSIGNATURE:_____

DATE:_____

ALL MEDCIATIONS ARE PRESCRIBED ELECTRONICALLY