Florida Foot & Ankle Group, P.A.

PATIENT INFORMATION

(Please Print)

Date________________________________

Last Name___________________________ First_____________________ MI_______ Sex: ❑ Male ❑Female

Address____

City____ State_______________ Zip________________

Date of Birth_________________________ Age________ Home Phone # (________)_______________________

Social Security #___________________________________ Cell Phone # (________)_______________________

Employer____ Work Phone # (________)_______________________

If Minor, Responsible Party________________________________ Phone # (________)_______________________

Emergency Contact______________________________________ Phone # (________)_______________________

Primary Physician (full name)______________________________ Phone # (________)_______________________

Marital Status:	❑ single	❑ married	❑ divorced	❑ widowed	
Work Status:	❑ employed	❑ full-time student	❑ part-time student	❑ retired	❑ none
Referral Source:	❑ doctor	❑ friend/family	❑ phone book	❑ insurance book	❑ other

INSURANCE INFORMATION

Primary Insurance____

Address____

____

Phone # (________) ________________________

Subscriber _______________________________ Subscriber's Date of Birth_____________________________

ID #_______________________________

Group # ____________________________ Subscriber's Employer________________________________

Relationship to Insured _____________________

Secondary Insurance____

Address____

____

Phone # (________) ________________________

Subscriber _______________________________ Subscriber's Date of Birth_____________________________

ID #_______________________________

Group # ____________________________ Subscriber's Employer________________________________

Relationship to Insured _____________________

Florida Foot & Ankle Group, P.A.

Patient Health History

Name______________________________ Age______ Sex______ Race________

Reason for todays visit____

____

Height______________ Weight______________ Shoe Size______________

Current Medical Conditions or Illnesses___________________________

____

Current Medications____

____

Allergies (drugs, iodine, tape, food)____________________________

List any hospitalizations or surgeries you have had______________

____

Do any family members have: ❑ Gout ❑ Foot problems ❑ Diabetes ❑ High blood pressure ❑ Blood or bleeding problems ❑ Heart problems ❑ Arthritis ❑ Cancer

Do you smoke cigarettes? ❑ No ❑ Yes ____________________

Have you ever smoked? ❑ No ❑ Yes ____________________

Do you drink alcohol? ❑ No ❑ Yes ____________________

Do you exercise? ❑ No ❑ Yes ____________________

Do you spend time on your feet at work? ❑ No ❑ Yes; Occupation______________

Family Doctor/Internist:______________________ Date last seen__________

Do you have, or have you had, any of the following conditions or illnesses:

No	Yes		No	Yes		No	Yes	
❑	❑	Arthritis	❑	❑	Poor circulation	❑	❑	Lung or breathing problems
❑	❑	Cancer	❑	❑	Bleeding problems	❑	❑	Trauma to feet or legs
❑	❑	Gout	❑	❑	Poor healing	❑	❑	Cramping of feet or legs
❑	❑	Tuberculosis	❑	❑	Nerve problems	❑	❑	Swelling of feet or legs
❑	❑	Diabetes Mellitus	❑	❑	Numbness in feet	❑	❑	Ear/eyes/nose/throat problems
❑	❑	Rheumatic Fever	❑	❑	Low back pain	❑	❑	Infections/contagious disease
❑	❑	Heart problems	❑	❑	Weight loss/gain	❑	❑	Hepatitis, AIDS, VD
❑	❑	Stomach ulcers	❑	❑	High blood pressure	❑	❑	Blood transfusion
❑	❑	Phlebitis	❑	❑	Liver problems	❑	❑	Stroke
❑	❑	Anemia	❑	❑	Kidney problems	❑	❑	Other______________

The above information is complete and accurate to the best of my knowledge. I hereby give permission to FL Foot & Ankle Group, P.A., to examine, perform necessary diagnostic testing, and treat my foot or ankle condition. I authorize photographing my feet.

Patient/Parent/Guardian Signature______________________________ Date__________

FLORIDA FOOT & ANKLE GROUP, P.A.

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, **Florida Foot & Ankle Group, P.A.,** may use and disclose Protected Health Information (PHI) about me to carry out Treatment and Payment Operations (TPO). Please refer to the **Florida Foot & Ankle Group, P.A.,** Notice of Privacy Practices (NPP) for a more complete description of such uses and disclosures.

I have the right to review the NPP prior to signing this consent. **Florida Foot & Ankle Group, P.A.,** reserves the right to revise its NPP at anytime. A revised NPP may be obtained by forwarding a written request to: **Florida Foot & Ankle Group, P.A., 925 Williston Park Point, Suite 1009, Lake Mary, FL 32746.**

With my consent, **Florida Foot & Ankle Group, P.A.,** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, **Florida Foot & Ankle Group, P.A.,** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Florida Foot & Ankle Group, P.A.,** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Florida Foot & Ankle Group, P.A.,** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Florida Foot & Ankle Group, P.A.,** to the use and disclosure of my PHI to carry out TPO. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents. I understand that, upon my request, I may view or receive a copy of the information referenced above, and a copy of this form after I sign it.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, **Florida Foot & Ankle Group, P.A.,** may decline to provide treatment to me.

__________________________________ ______________________
Signature of Patient or Legal Guardian Date

____
Patient’s Name

____
Print Name of Patient of Legal Guardian

SIGNATURE ON FILE FORM

FLORIDA FOOT & ANKLE GROUP, P.A.

I hereby give consent to **Florida Foot & Ankle Group, P.A.** to provide whatever treatment the assigned physicians may deem necessary to the patient named below.

I understand that I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to **Florida Foot & Ankle Group, P.A.** for Professional Physicians fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by my insurance policy and will pay balances in full within 30 days of the first billing statement. A rebilling fee of $10.00 will be added for each additional billing statement sent. All collection fees incurred by **Florida Foot & Ankle Group, P.A**. will be my responsibility.

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to **Florida Foot & Ankle Group, P.A.** for any services furnished me by **Florida Foot & Ankle Group, P.A.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to process the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned claims, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Name of Responsible Party:____

Signature:______________________________________ Date:__________________

(Form revised 11/04)