SOUTH FLORIDA PODIATRY

Medical, Surgical
& Cosmetic Care
For Your Foot And Ankle

954.426.4544
Fax: 954.426.4533
1874 W Hillsboro Boulevard, Suite F
Deerfield Beach, FL 33442

PLEASE PRINT CLEARLY. (This information will be used to contact you regarding appointments and other medical information)

NAME: _____ SOCIAL SECURITY # _____ SEX: ☐ F ☐ M

INSURANCE NAME: _____

MEMBER ID: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL(call/text) : _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REASON FOR VISIT: _____

SURGERIES: ☐ None ☐ Foot Surgery ☐ Vascular Surgery ☐ Heart Surgery ☐ Other: _____

PATIENT HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ Ankle pain	☐ Anxiety	☐ Back Pain	☐ Chest Pain	☐ Chills/Fever	☐ C.O.P.D.	☐ Diabetes	☐ Dry Skin
☐ Fainting	☐ Gout	☐ Heart Attack	☐ Heartburn	☐ Heel Pain	☐ Hepatitis	☐ High BP	☐ Hip Pain
☐ Nausea	☐ Leg Cramps	☐ Melanoma	☐ Asthma	☐ Liver Disease	☐ Pacemaker	☐ Psoriasis	☐ Foot Wart
☐ Aids/HIV	☐ Anemia	☐ Cellulitis	☐ Blood Clots	☐ Arthritis	☐ Stroke	☐ Seizures	☐ Cancer
☐ Athletes Foot	☐ Ulcer	☐ Kidney Disease		☐ High Cholesterol		☐ Shortness of Breath	

OTHER: _____

PLEASE LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER

☐ NONE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES to MEDICATION

☐ None ☐ Iodine ☐ Latex ☐ Local Anaesthetic ☐ Penicillin ☐ Sulfa ☐ Other _____

SOCIAL HISTORY

TOBACCO USE: ☐ NEVER ☐ FORMER ☐ SOMETIMES ☐ EVERYDAY # PACKS/DAY _____

ALCOHOL USE: ☐ NEVER ☐ FORMER ☐ SOMETIMES ☐ EVERYDAY

FAMILY HISTORY (CIRCLE THE APPLICABLE LETTER - Brother / Sister / Mother / Father)

☐ Diabetes B / S / M / F ☐ Cancer B / S / M / F ☐ Heart Disease B / S / M / F

HEIGHT _____ WEIGHT _____

IF YOU ARE DIABETIC: LAST BLOOD SUGAR _____ LAST A1c _____ SHOE SIZE: _____

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Consent for Assignments of Benefits

I hereby give consent to South Florida Podiatry to apply for benefits from the insurance carrier(s), whose name I have provided, and further give consent that all payments be made directly to South Florida Podiatry of the surgical and /or medical benefits, if any, otherwise payable to me for services rendered by South Florida Podiatry

Authorization to South Florida Podiatry if Adverse Benefit Determination

I also authorize South Florida Podiatry to act as my representative, should they need to contact my insurance company to appeal an adverse benefit determination.

*MEDICARE ONLY

I request that payment of Medicare benefits given consent to by me, be made on my behalf to South Florida Podiatry for any services furnished to me by South Florida Podiatry I consent to any holder of medical or other information about me to release to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or the benefits for related services. Federal Law requires that physicians collect the yearly deductible and 20% co-payments from the patient.

Consent for Treatment and Release of Information

I hereby give consent to South Florida Podiatry to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment. Further
, I give consent to South Florida Podiatry to disclose complete information concerning records regarding the illness or accident to any collateral source (in the case of Medicare, the Social Security Administration and the Centers for Medicare and Medicaid) that will pay part or all of said medical bills.

*FINANCIAL AGREEMENT

I understand that all bills for the doctor's services are due from me when rendered, and I am completely responsible for these charges regardless of any third-party interest, payor or the resolution of any legal action or lawsuits in which I may be involved. I further understand that South Florida Podiatry reserves the right to pursue delinquent accounts via third-party collection agencies or attorneys. In the event the physician refers my bill for collections, I agree to pay an additional $35.00 to cover the services of processor costs to said physician in addition to the amount owed for the services rendered.

Privacy Practices

I acknowledge that the Notice of Privacy Practices was made available for me and that I have read (or had the opportunity to read if so chose) and understand the Notice as required by the Federal Law. This Consent and Assignment of Benefits is valid for all episodes of care rendered by South Florida Podiatry.

Signature of Patient (or guarantor, if minor):_____ Date_____