PODIATRY ASSOCIATES OF FLORIDA
PATIENT INFORMATION FORM

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: M F

Home Address: _____

City: _____ State: _____ Zip: _____

Home # _____ Cell #: _____

Email: _____
May we leave you a message at the above number and/or email address? Yes No (circle one)

****

Emergency Contact:
Name: _____

Relationship: _____ Phone #: _____

****

Is there a family member or other person you would like for us to share your medical information with?
Yes No Name: _____

Who is responsible for payment? _____

Relationship to patient? _____ Phone #: _____

****

Primary Care Doctor:_____ Phone #:_____

Pharmacy Name: _____ Phone #: _____

Address: _____

****

How did you hear about us? (circle one)
Google Social Media Friend/Relative (Name _____)

Other _____

Please list all the medications that you are currently taking (prescriptions, over the counter and herbal supplements). Include dosage and how often you take.

_____

_____

_____

_____

_____

_____

Please list all prior surgeries, type of surgery and surgery date.

_____

_____

_____

_____

Social History *(check all that apply)*

Use of alcohol:

Current use: Rare _____ Occasional _____ Moderate _____ Daily _____ Never _____ No Longer Use _____
History of alcohol abuse _____

Use of tobacco:

Current use: How much/often? _____ Type _____

Never _____ Quit – How long ago? _____ Smoked Packs/Day for _____ Years

Use of recreational drugs:

Current use: Rare _____ Occasional _____ Moderate _____ Daily _____ Never _____

Quit – How long ago? _____ Type: _____

****

Family History *(check all that apply)*

Do you have a family history of: Diabetes _____ Cancer _____ Heart Disease _____ Stroke _____

High blood pressure _____ Coronary Heart Disease _____ Thyroid Disease _____

Rheumatoid Arthritis _____

Other _____

Medical History

Allergies: ***(check all that apply)*** None Known _____Latex _____ Iodine _____ Tape _____ Anesthesia _____

Other: _____

Foods:_____

Have you ever had any of the following? ***(circle yes or no to all that apply)***

Abnormal Bleeding	Yes	No	Fibromyalgia	Yes	No	Neuropathy	Yes	No
Acid Reflux	Yes	No	Gout	Yes	No	Open Sores	Yes	No
Anemia	Yes	No	Heart Attack	Yes	No	Pneumonia	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No	Polio	Yes	No
Back Trouble	Yes	No	HIV / AIDS	Yes	No	Rheumatic Fever	Yes	No
Bladder Infections	Yes	No	High Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No
Blood Clots	Yes	No	Kidney Disease	Yes	No	Skin Disorder	Yes	No
Blood Transfusion	Yes	No	Liver Disease	Yes	No	Sleep Apnea	Yes	No
Cancer	Yes	No	Low Blood Pressure	Yes	No	Stomach Ulcers	Yes	No
Diabetes	Yes	No	Migraines	Yes	No	Stroke	Yes	No
Emphysema	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No

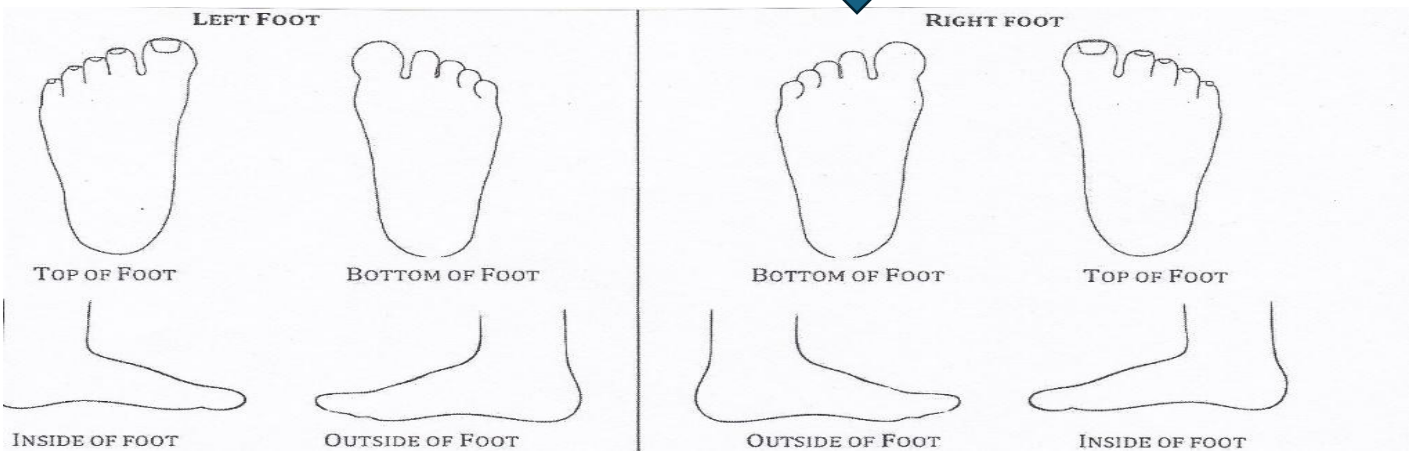
Current Problem

What ***SPECIFIC*** problem brings you into our office today? ***(Please explain in writing)*** _____

_____

_____

Where is the pain located? Please mark on the pictures below.



How long ago did today's problem first start? _____ Days / Weeks / Months / Years ***(circle one)***

Did your pain/problem: ***(check one)*** Begin suddenly? _____ Gradually develop over time? _____

How would you describe your pain? ***(check all that apply)*** Sharp _____ Dull _____ Aching _____ Burning _____
Radiating _____ Itching _____ Stabbing _____ Other _____

How would you rate your pain on a scale from 0 -10? ***(Please circle one)***
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)
Since the time your pain/problem began, has it: ***(check one)*** Stayed the same _____ Become worse _____
Improved_____

What makes your pain/problem feel worse? ***(check all that apply)***
Running _____Walking _____ Standing _____ Daily Activities _____ Resting _____ Dress Shoes _____ High Heels ____ Flat Shoes _____ Any closed toe shoe _____ Other: _____

What makes your pain feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or your ability to work? _____

_____

Was this problem caused by an injury? Yes _____ Describe _____
No _____

If yes, was it a work-related injury? Yes _____ No _____

Employer: _____ **Occupation:** _____

How much are you on your feet at work?

10% _____ 25% _____ 50% _____ 75% _____ 100% _____

Exercise: Never _____ Rare _____ Occasional _____ Weekly _____ Several times a week _____

Daily _____ **Type:** _____

Please Circle:

Language: English Spanish Other _____

Ethnicity: Asian Black Pacific Islander Hispanic Caucasian

Other _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous for 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, relationship to patient

_____
Signature Date

Podiatry Associates of Florida, Inc.

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____

Patient Name Date

_____

Signature

_____

Parent or Guardian Signature

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Fax: 904-260-1523
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PATIENT FINANCIAL AGREEMENT

This letter sets forth the financial 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 any 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/her for these services are matters which concern my doctor and myself. 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 (i.e., insurance company, employer, etc.).

I, the undersigned, do hereby authorize the release of 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 $30.00. Accounts with no activity for sixty (60) days will be forwarded to further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all the 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 $30.00 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:

- 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.
- I will pay for all applicable copays and any outstanding patient balances as they become due. Copays and any outstanding patient balance is due at each visit.
- Deductibles are due at the time of service.
- Surgery copays/co-insurance/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

Print name: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____