475 Biltmore Way, Suite 402
Coral Gables, FL 33134
Phone: 305-444-7870
Fax: 305-444-7807

ATLANTIC
FOOT & ANKLE, LLC

92410 Overseas HWY, Suite 1
Tavernier, FL 33070
Phone: 305-852-8395
Fax: 305-852-8397

PATIENT REGISTRATION

DEMOGRAPHICS:

Patient Name: _____ SS#: _____

Address: _____ APT #: _____

City: _____ State: _____ Zip: _____ Home #: _____ Cell #: _____

Birth date: _____ Age: _____ Sex: M F Marital Status: S M D W

IF PATIENT IS RESPONSIBLE PARTY, PLEASE FILL OUT THE INFORMATION BELOW FOR YOURSELF. IF PATIENT IS A MINOR, PLEASE COMPLETE BELOW FOR PARENT/GUARDIAN

Responsible Party: _____ Driver License #: _____

Employer: _____ Employer Address: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Birth Date of Insured: _____ SS#: _____ How did you hear about us? _____

INSURANCE INFORMATION:

Primary Insurance:	Member ID:	Group/ Acct #:
_____	_____	_____
Policy Holders Name:	**Birth Date:**	**Relation to Patient:**
_____	_____	_____
Secondary Insurance:	**Member ID:**	**Group/ Acct #:**
_____	_____	_____
Policy Holders Name:	**Birth Date:**	**Relation to Patient:**
_____	_____	_____

PHARMACY INFORMATION:

Name: _____ Location/ Zip: _____ Phone: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR ANY APPLICABLE COPAY, DEDUCTIBLE OR NON-COVERED SERVICES. HOW DO YOU WISH TO PAY FOR PATIENT RESPONSIBILITY AMOUNT TODAY?
CASH: _____ CREDIT CARD: _____

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO ID TO OUR RECEPTIONIST. COPIES WILL BE MADE FOR YOUR RECORDS.

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PATIENT MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Primary Care Physician: _____ Who referred you to our office: _____

Are you here today due a WORK INJURY? NO YES, if so - What is the Date of Injury: _____

Height: _____ Current Weight: _____ Shoe Size: ____ Shoe Preference: _____

Do you have a Personal History of? (Please check all that apply):

___ Diabetes
___ High Cholesterol
___ High Blood Pressure
___ Asthma
___ Epilepsy
___ Liver Disease
___ Heart Disease
___ Thyroid Disorder
___ Prolonged Bleeding
___ Kidney Disease
___ Back Injury
___ Pacemaker
___ Rheumatic Fever
___ Mitral Valve Prolapse
___ Blood Clot or DVT
___ Gastric Reflux or Stomach Problems
___ Injury to your Feet, Ankles, or Legs
___ Nervous Disorder, Fainting, or Dizziness
___ Liver Disease, Hepatitis
___ Mitral Valve Prolapse
___ NONE
___ OTHER, please list

Do you or have you....
Drink Alcohol: _____ Number of drinks per week: _____
Smoke Cigarettes: _____ Number per day _____ For how many years: _____
Use Recreational Drugs: _____ Please list: _____

Have you had any surgeries in the past? Please list:	Are you currently taking any medication? Please list:
Please describe your activity level?	
Significant Family History:	Do you have any allergies to any medicine or food? Please list:

I UNDERSTAND THAT HONEST AND COMPLETE ANSWERS TO EACH QUESTION STATED ABOVE ARE IMPORTANT TO THE PROVISION OF MY MEDICAL CARE AND I HAVE ANSWERED THEM TO THE BEST OF MY ABILITY. I HAVE BEEN INFORMED THAT IF I AM UNCERTAIN ABOUT ANY QUESTION ON THE FORM I SHOULD ASK THE DOCTOR OR A MEMBER OF THE OFFICE STAFF FOR ASSISTANCE.

Form Completed by: _____ Date: _____

PLEASE CHECK OFF ANY OF THESE PROBLEMS YOU HAVE CURRENTLY EXPERIENCED

EENT

- ☐ NORMAL
- ☐ Nose Bleed
- ☐ Difficulty swallowing
- ☐ Difficulty chewing
- ☐ Visual problems
- ☐ Glasses
- ☐ Contact lenses
- ☐ Hearing problems
- ☐ Sore in mouth that will not heal
- ☐ Thyroid problems

CARDIOVASULAR

- ☐ NORMAL
- ☐ Chest pain/ angina
- ☐ Swelling of feet or ankles
- ☐ Abnormal heart rhythm
- ☐ Abnormal EKG
- ☐ Rapid heart rate
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Blood clot in leg

LIVER

- ☐ NORMAL
- ☐ Yellow skin/ Jaundice

SKELETAL/MUSCULAR

- ☐ NORMAL
- ☐ Rash
- ☐ Sore not healing
- ☐ Limited motion in joint
- ☐ Back problems

MENTAL HEALTH

- ☐ NORMAL
- ☐ Panic attack
- ☐ Agoraphobia

NEUROLOGICAL

- ☐ NORMAL
- ☐ Numbness of the arms or legs
- ☐ Fainting
- ☐ Dizziness
- ☐ Seizures
- ☐ Headache

RESPIRATORY

- ☐ NORMAL
- ☐ Abnormal chest X-ray
- ☐ Use oxygen at home
- ☐ Blood clot in lung
- ☐ Chronic cough
- ☐ Blood in sputum

GASTROINESTINAL

- ☐ NORMAL
- ☐ Abdominal pain
- ☐ Ulcer in stomach
- ☐ Nausea or vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in appetite
- ☐ Unexplained weight loss
- ☐ Heart burn
- ☐ Gall bladder problem

HEMATOLOGIC

- ☐ NORMAL
- ☐ Bleeding disorder
- ☐ Petechial
- ☐ Easily bruising/bleeding
- ☐ OBD

GENITOURINARY

- ☐ NORMAL
- ☐ Difficulty in urinating
- ☐ Frequent infection
- ☐ On dialysis
- ☐ Abnormal bleeding

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. *MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.*

_____ _____

Please ***print*** your name — Please ***sign*** your name

_____ _____

Legal Representative — Description of Authority

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer

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CONSENT TO TREATMENT

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetic and any and all medication or technical procedures which in the judgment of the physician(s) may be considered necessary or advisable for the diagnosing or treating of my condition.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of insurance benefits directly to Atlantic Foot and Ankle, LLC. Where MEDICARE BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that the payment of authorized benefits be made on my behalf.

GUARANTEE OF PAYMENT

For services rendered, I guarantee payment of any and all charges incurred which are not covered or allowed by my insurance or Medicare. I also understand that I am fully responsible for any denial of payment due to lack of medical necessity or pre-certification or constraint imposed as a condition of my insurance coverage. It is further agreed that if this account be referred for collection, I will pay the costs relating to any and all collection efforts.

NON COVERED MEDICAL SUPPLIES

From time to time your treating physician may find it necessary to recommend medical supplies to aid in the treatment of your condition. These supplies are not covered by your insurance company. Payment will be expected at the time of service. If you do not wish to purchase a recommended supply, please notify the Doctor or Nurse of your decision.

CONSENT FOR BASIC USE OF YOUR PROTECTED HEALTH INFORMATION

I hereby give my consent for Atlantic Foot and Ankle, LLC to use and disclose protected health information (PHI) about me to carry our treatment, payment and healthcare operations (TPO). This includes but is not limited to: (1) The practice may call my home or other alternative 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 issues and any calls pertaining to my clinical care, including laboratory results among others. (2) The practice may mail to my home or other alternative location any items that assist the practice carrying out TPO, such as patient statements as long as they are marked Personal and Confidential. *For a complete description of such uses and disclosures please refer to our Notice of Privacy Practices.* By signing this form I am consenting to Atlantic Foot and Ankle, LLC the use and disclosure of PHI to carry out TPO.I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Atlantic Foot and Ankle, LLC may decline to provide treatment to me.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name of Patient or Legal Guardian