PODIATRY
ASSOCIATES OF FLORIDA
Foot & Ankle Specialists

NEW PATIENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:
Date Of Birth:	Gender: ☐ Female ☐ Male	SSN:
Address:		
City:	State:	ZIP:
CELL PHONE #:	HOME PHONE #:	EMAIL:

We are required to ask the following questions, however, you may choose not to answer:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White ☐ Black or African American ☐ American Indian / Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ Other/Decline

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Other/Decline

IF PATIENT IS A MINOR - PARENT INFORMATION:

First Name:	Last Name:
Date of Birth:	SSN:

REASON FOR TODAY'S VISIT:

____

____

HOW DID YOU HEAR ABOUT US?

☐ Insurance, ☐Internet/Web, ☐Physician: ____________________, ☐Family/Friend, ☐Other: ____________________

Check if you have seen any of our other providers within last 3 years:

☐Dr. Bleau, ☐Dr. Efron, ☐Dr. Herbst, ☐Dr. Lagoutaris, ☐Dr. Matey, ☐Dr. Tillo, ☐Dr. Yant

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY #1:	
Policy Holder Name:	
Member ID:	Effective Date:
Policy Holder's Date of Birth:	
Policy Holder's Social Security #:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent	
Is Referral Required? ☐ Yes ☐ No	

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY #2:	
Policy Holder Name:	
Member ID:	Effective Date:
Policy Holder's Date of Birth:	
Policy Holder's Social Security #:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent	
Is Referral Required? ☐ Yes ☐ No	

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YOUR NAME:_______________________________ DOB:________________ TODAY'S DATE:______________

SURGICAL HISTORY (List all your surgeries in the past 5 years)

1.	Year:
2.	Year:
3.	Year:
4.	Year
5.	Year:

PAST MEDICAL HISTORY (Check any of the following if you still have, or have ever had)

☐ AIDS/HIV	☐ Epilepsy	☐ Kidney Problems	☐ Psychiatric Care
☐ Anemia	☐ Fainting	☐ Liver Problems	☐ Rheumatoid Arthritis
☐ Arthritis	☐ GERD	☐ Lung Disease	☐ Seizures
☐ Asthma	☐ Gout	☐ Melanoma	☐ Swelling Ankle/Feet
☐ Bleeding Tendencies	☐ Headaches	☐ Neuropathy	☐ Stomach Ulcers
☐ Cancer	☐ Heart Disease	☐ Osteoporosis	☐ Stroke
☐ Chest Pain	☐ Hemophilia	☐ Pneumonia	☐ Tuberculosis (TB)
☐ Circulatory Problem	☐ Hepatitis	☐ Problems with Anesthesia	☐ Varicose Veins
☐ Diabetes	☐ High Blood Pressure	☐ Psoriasis	☐ Venereal Disease

Can You Take Aleve/Advil/Aspirin Without Problems?

☐ Yes ☐ No

Women – Are You Pregnant Or Possibly Pregnant?

☐ Yes ☐ No

Are you Diabetic? ☐ Yes ☐ No

If Yes, Who Is Your Supervising Provider? (PCP or Endocrinologist)

____

Date Of Last PCP/ENDO Appointment: ___________________

CURRENT MEDICATIONS (☐ no medications / ☐ list attached) **ANY KNOWN ALLERGIES** (☐ no known allergies)

Current Medications	Known Allergies
1.	1.
2.	2.
3.	3.
4.	4.

YOUR SOCIAL HISTORY

Do You Use Tobacco? ☐ Yes ☐ No	Do You Use Alcohol? ☐ Yes ☐ No

YOUR FAMILY HISTORY (Please Indicate **M** for Maternal, **P** for Paternal, or **S** for Sibling)

☐Cancer	☐Gout	☐Heart Disease	☐Sickle Cell Disease
☐Diabetes	☐Heart Attack	☐High Blood Pressure	☐Stroke

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YOUR NAME:______________________________________ DOB:________________ TODAY'S DATE:________________

PATIENT CONTACTS

YOUR PRIMARY CARE PROVIDER (PCP):	PCP Phone #:
PCP Address:	
PHARMACY:	Pharmacy Phone #:
Pharmacy Address/Location:	
EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone #:	
PLACE OF EMPLOYMENT:	Employer Phone #:
What Type of Work Do You Do?	

YOUR HEIGHT:__________ **YOUR WEIGHT:__________** **YOUR SHOE SIZE:__________**

PAYMENTS: CoPays are due at time of service (which includes Medicare patients). Selfpay patients are required to pay in full at time of service. Your medical claim will be forwarded to your secondary insurance (if any) after payment is received from your primary insurance. You are required to follow the guidelines of your managed care plan. You must have a referral from your primary if your plan requires one. If one is not provided, you can be held financially responsible for service. You will be sent up to three notices for your financial responsibility after payment is received from your insurance company. After the third notice, your account will be forwarded to collections. An additional $25.00 will be added to your account for all returned checks. You are to inform the doctor's office if there are any changes in your health insurance information. You agree to pay Podiatry Associates of Florida for any remaining balance after insurance payment has been made.

AUTHORIZATION AND ASSIGNMENT: For The Services Rendered And Those About To Be Rendered, I Hereby Assign To **P**odiatry **A**ssociates **o**f **F**lorida (hereinafter referred to as "PAOF"} All Medical And/Or Surgical Benefits Otherwise Payable To Me Under The Above Described Policy Not To Exceed The Charges Made For Such Services. I Further Direct That They Make No Payments To Me. In The Event That I Receive Payment From The Insurance Company I Agree To Endorse Such Payment To **PAOF** Immediately. I Understand That I Am Directly And Primarily Responsible To **PAOF** For their Usual And Customary Fee For The Services Rendered To Me. I Realize That If My Insurance Company Fails To Pay Or If There Is A Delay (More Than 75 Days) In Their Paying It Is My Sole Responsibility To Promptly Pay My Doctors Bill Directly. I Further Understand And Agree If I Fail To Make Prompt And Timely Payments To **PAOF** I Will Be Directly Responsible For Any And All Costs Of Collection Including Filing Fees As Well As Reasonable Attorney Fees. I Hereby Authorize **PAOF** To Release To My Insurance Company Any Information Acquired, Including The Diagnosis And The Records In Course Of My Examination And Treatment. I Acknowledge That I Was Provided A Copy Of The Notice Of Privacy Practices And Have Read (Or Had The Opportunity To Read If I Chose) And Understand The Notice.

I CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. **Initial:________ Date:________**

DIABETIC PATIENTS ONLY

AUTHORIZATION AND ASSIGNMENT: Diabetes is a serious metabolic disease that usually affects your feet. The disease affects the way your body uses sugar and how it produces insulin. Today medicine has advanced significantly in treating the dangerous effects of abnormal blood sugar like hyperglycemia, ketoacidotic coma, infection and premature death. This is both good and bad news. The good news is that people with diabetes are living longer, healthier lives. The bad news is that diabetes still causes secondary indirect complications that affect the feet, eyes and kidneys. Diabetic foot disease is primarily caused by two complications of the disease called neuropathy and atherosclerosis (poor circulation).

Neuropathy is nerve damage of the foot causing numbness and loss of sensation. This loss of sensation makes it difficult for the patient to distinguish between hot and cold or to realize when the foot has been cut or bruised. In a way your feet become “unprotected” because of the neuropathy. Ulcers, cuts, scrapes, burns and other trauma to your feet can go unnoticed until it’s too late to avoid serious problems like infection or gangrene.

Atherosclerosis causes a diabetic to have poor circulation, which adversely affects the legs and feet. Additionally, white blood cells which fight infection do not perform effectively when blood sugar levels are higher than normal. This can seriously compound any foot problems because the body’s defenses may be unable to prevent the development of cellulitis (infection of the skin), abscess (infection of soft tissue under the skin) or osteomyelitis (infection in your bone). This can result in foot ulcers (that won’t heal), gangrene and even amputations. IT IS IMPORTANT TO REMEMBER THAT THESE ARE DIRECT COMPLICATIONS OF THE DISEASE. While statistics show that early, conservative, preventive, management of diabetic foot disease can effectively reduce or delay these bad results, there is no cure for diabetes and bad results may be unavoidable even with the best care. Unfortunately, that is the nature of your disease.

A daily foot care instruction sheet will be given to you by our office and you should follow these instructions and the specific instructions we give you upon examination. It is VERY important that you keep your blood sugar under good control. It is YOUR RESPONSIBILITY to see your internist and family doctor for management of your disease. If you fail to do so it will adversely affect our treatment of your feet.

We wish you the best of health and will work very hard with you to keep your feet in the best condition your disease will allow.

Sincerely,
Physicians at Podiatry Associates of Florida.

I have read and understand this letter and I agree to have diabetic foot care performed at Podiatry Associates of Florida including: trimming of corns, calluses, nails, care of ulcers and routine foot care as needed.

FULL NAME ____

SIGNATURE ____ DATE SIGNED ______________________