Advanced Foot & Ankle Specialists, P.A.

PATIENT INFORMATION

Name_____ DOB _____ Age _____

Mailing Address_____

City/State _____ Zip _____

Northern Address _____

City/State _____ Zip _____

Phone # _____ Out of State# _____

Cell#_____ Work# _____

SSN #_____ Male _____ Female _____

Email Address:_____

Marital Status: _____Single _____ Married _____Widowed _____ Divorced

Employer _____Phone_____

Emergency Contact _____Phone _____

Primary Physician _____Phone_____

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral(who?)_____

Insurance Company_____ Facebook_____ Other_____

Race: (Please Circle) American Indian or Alaskan Native (AI), Asian (A), Black (B), Caucasian (C), Other (E), Pacific Islander (P), Declined (7)

Ethnicity: Hispanic____ Non-Hispanic___

Primary Language: _____

Primary Insurance Information

Insurance Co. Name _____

Subscriber Name _____DOB_____

Relationship to Patient _____SSN# _____

Secondary Insurance Information

Insurance Co. Name _____

Subscriber Name _____DOB _____

Relationship to Patient _____SSN# _____

Is there a 3rd Insurance Carrier? _____

What is your reason for today's visit? _____

Is today's visit the result of an accident or injury? Yes_____ No _____

Date of accident_____

Any other liable party from accident? _____

_____

GENERAL MEDICAL HISTORY

Check all that apply

___Anemia	___Circulation Problems	___High Blood Pressure	___Rheumatic Fever
___Arthritis	___Diabetes	___Intestinal Problems	___Seizure Disorder
___Asthma	___Ear Trouble	___Kidney Disease	___Stomach Disorders
___Blood Disorders	___Eye Trouble	___Liver Disease	___Stroke
___Bronchitis	___Gout	___Phlebitis	___TB
___Cancer	___Heart Trouble	___Prolonged Bleeding	___Other_____

Operations/Hospitalizations

Year Conditions

_____
_____
_____
_____
_____
_____

Do you have a Living Will? ____yes ____no

I hereby assign to Advanced Foot & Ankle Specialists, P.A. all payment for medical services rendered to myself or my dependent listed above. I understand that I am responsible for any amount not covered by insurance. I also authorize release of medical information necessary to process any health insurance claim.

Signature_____**Date**_____

ADVANCED FOOT & ANKLE SPECIALISTS, PA

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name:_____Date of birth:_____

I hereby authorize **Dr. Weingarten and/or Advanced Foot & Ankle Specialists, PA** to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Specific persons/organizations to receive the information_____

_____

_____

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**

Or specify one or more of the following:

- ☐ Operative Reports
- ☐ Progress Notes
- ☐ Laboratory
- ☐ X-rays
- ☐ Billing and Claim Records
- ☐ (Other – specify)

This information is to be used/disclosed for the following purposes(s) only: _____
_____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

****You are entitled a copy of this document****

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____

Relationship to the patient (if applicable):_____

Advanced Foot & Ankle Specialists, P.A.
Jay S. Weingarten, DPM, FACFAS, FACFAOM
Podiatric Physician & Surgeon

Acknowledgment of receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature

Advanced Foot & Ankle Specialists, P.A.
Jay S. Weingarten, DPM, FACFAS, FACFAOM
Podiatric Physician & Surgeon

Private Insurance, PPO, HMO, and EPO/POS Plans and Self Pay

1. This office will file your insurance. You are responsible for all co-payments, deductibles and non covered services. Our office does NOT verify insurance following the initial visit. **It is your responsibility to report insurance changes to us promptly to avoid claim denials (as Florida has time limits for filing claims).**
2. Co-pays, deductibles and non-covered charges are due at time of service. We accept cash, check and major credit cards for payment of charges.
3. Returned checks are subject to additional fees as per Florida Statutes. Balances over 90 days may be subject to additional interest of 1.5% per month. Accounts over 120 days will be placed with an outside collection agency unless prior arrangements are made with the office. Accounts sent to a collection agency will incur an additional collection fee of 35% of their outstanding balance.

We are confident that, by being participating providers, we will be able to provide excellent comprehensive podiatric services to our insurance patients.

Thank you for your cooperation.

_____

Signature of patient or patient representative Date

_____

Relationship of representative

ADVANCED FOOT & ANKLE SPECIALISTS, PA

Current Medication List

Patient Name: _____ Date of Birth: _____

Dosage	Frequency

Do you ***currently*** smoke? □ YES □ NO

Are you a ***former*** smoker? □ YES □ NO

Drug User (substance abuse)? ____yes _____no

Do you drink alcoholic beverages? ____no ___yes _____how often?

Drug Allergies:

_____

Patient Signature Today's Date