PATIENT INFORMATION

First: _____ M.I._____ Last: _____

Preferred Name: _____ Sex: ☐ M ☐ F DOB: _____

Social Security #: _____

Mobile Phone: _____ E-mail: _____

Home Phone: _____ Work Phone: _____

Preferred method of communication: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Insurance Name: _____

Policy # _____ Group # _____

Patient relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor Name: _____

Guarantor Address: _____

Guarantor City: _____ State: _____ Zip Code: _____

Guarantor DOB: _____ ☐ M ☐ F Social Security #: _____

Guarantor Phone: _____ Secondary Phone: _____

Patient's Ethnicity: _____ Language: _____ Patient's Race: _____

Primary Doctor: _____ Last Visit: Month _____ Year_____

How did you hear about us? _____

Pharmacy: _____ Phone Number: _____

Prescription History

In order to have the most current prescription information, we need to request the information electronically. Do we have permission to do so? ☐ Yes ☐ No

Signature: _____ Date: _____

Primary Doctor: _____ Phone No: _____ Date of last exam: _____

Describe the condition that brought you to this office: _____

If auto accident, date of accident _____ Previous care for this condition? ☐ Yes ☐ No

Dr. _____ Date: _____

HEIGHT: _____ WEIGHT: _____

MEDICAL: (Please check any of the following if it pertains to you)

___ Diabetes	___ Phlebitis	___ Scar Former	___ Asthma
___ Angina/Chest Pain	___ Bleeding Disorders	___ Angioplasty	___ Depression
___ Kidney Disorder	___ Seizures	___ Ulcers	
___ Human Immunodeficiency Virus (HIV)	___ Circulation Disorder	___ ADHD	
	___ Stroke/TIA's	___ High Blood Pressure	
___ Heart Attack	___ Bipolar	___ Hepatitis	

ALLERGIES:

___ None ___ Penicillin ___ Aspirin ___ Codeine ___ Novocain ___ Iodine ___ Latex

Other: _____

MEDICATIONS: (Please include Aspirin, Tylenol, Vitamins and Birth Control Pills) ___ See attached list

1 _____ 2 _____ 3 _____ 4 _____

PREVIOUS SURGERIES AND HOSPITALIZATIONS:

1 _____ 2 _____ 3 _____ 4 _____

Please check all the apply

FAMILY HISTORY: ☐Diabetes ☐High Blood Pressure ☐Bleeding Tendencies ☐Other

SOCIAL HISTORY:

Alcohol Intake	☐None	☐Occasional	☐Moderate	☐Heavy
Caffeine Intake	☐None	☐Occasional	☐Moderate	☐Heavy
Illicit Drugs	☐None	☐Occasional	☐Moderate	☐Heavy
Exercise Level	☐None	☐Occasional	☐Moderate	☐Heavy
Smoking Status	☐Never	☐Former	☐Current	
General Stress Level	☐Low	☐Medium	☐High	
Live alone or with others?		☐Alone	☐Others	
Single or multi-level home?		☐Single	☐Multi	

PODIATRIC HISTORY:

___ Flat Feet	___ Pain or fatigue in feet & legs with activity
___ Heel or arch pain (Child or Adult)	___ Numbness and tingling in feet and toes
___ Pain in feet getting out of bed	___ Bunions (prominent foot bones)
___ Crooked toes (hammertoes)	___ Ankle swelling & stiffness
___ Ankle instability (easy twisting injuries)	___ Leg pain (shin splints)
___ Growing pains	___ Difficulty walking/running
___ Poor coordination with sports	___ In-toe or out-toe gait
___ Abnormal foot posture (clubfoot, metadductus)	___ Achilles' tendon pain

Other problems with your feet/legs: _____

SOUTH FLORIDA LOWER EXTREMITY CENTER
Nooshin Zolfaghari D.P.M., / Igor Zilberman D.P.M.
2699 Stirling Road Suite A301/302
Hollywood, FL 33312
Office (954) 278-3890 / Fax (954) 251-1470

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: I _____,
Do hereby IRREVOCABLY ASSIGN to the above-named medical provider, any right or benefits under my policy of insurance with _____, for any service and/or charges provided by the above medical provider. Pursuant to this ASSIGNMENT OF BENEFITS, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. As part of this ASSIGMENT OF BENEFITS, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **South Florida Lower Extremity Center** is to be set aside and not disbursed until the dispute is resolved.

IN WITNESS WHEREOFF the undersigned has hereunto set his/her hand, this ___ day of _____, 20___.

_____ _____

Patient's Signature Patient's Name (please print)

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ACKNOWLEDGEMENT OF RECEIPTS OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

(Read before singing the Acknowledgement and Consent)

This Acknowledgement of notice and consent authorizes **South Florida Lower Extremity Center** to use health information about you for treatment, payment, and health care operations purposes.

NOTICE OF PRIVACY PRACTICES: South Florida Lower Extremity Center has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to conduct our Privacy Officer

Mail: 2699 Stirling Road Suite A301/302 Hollywood FL 33312
Tel: (954) 278-3890 /Fax: (954) 251-1470

Acknowledgement and Consent

I have received the Notice of Privacy Practices for **South Florida Lower Extremity Center** is authorized to use health information about (please print patient's name) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____	_____	_____
Signature of Patient	Date	Account #

Personal representative information (if applicable):

_____	_____
Name of Personal Representative	Relationship to Patient

IDENTITY OF RECEPIENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message: ☐YES ☐NO

___ Daytime phone / Ph# _____
___ On my home answering machine / Ph# _____
___ On my voicemail / Ph# _____
___ With my designated and authorized person(s) named below:

_____

2699 Stirling Road Suite A301/302 Hollywood, FL 33012 Office: (954) 278-3890 / Fax: (954) 251-1470

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. **As of January 01, 2018, there will be a fee of $25 assessed if we do not receive a 24 hours call prior to your appointment time.**

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Thank You,

The Staff of South Florida Lower Extremity Center

*I **acknowledge** and **accept** the cancellation policy.*

_____ _____

Please Print Name *Date*

_____

Patient's Signature