BOCA RATON PODIATRY, P.A.
950 GLADES ROAD #2A BOCA RATON, FL 33431
(561) 395-4243 fax 561-392-8353
www.bocaratonpodiatry.com

Patient Information

Name:_____ **Date of Birth**:_____ **Age**: _____

Address: _____
Street Apt. # City State Zip

Seasonal Address: (If different than above address)

Address: _____
Street Apt. # City State Zip

S.S. #:_____-_____-_____ **Sex:** M F **Marital Status:** M S D Sep W Partnered

Phone: **Home** ( )_____ **Work** ( )_____ **Cell** ( ) _____

Email:_____

What is your primary language? _____

Who is your primary care physician? _____

Address: _____
Street Apt. # City State Zip

How were you referred to our office? _____

Please specify your race

o American Indian or Alaska Native o Asian o Black or African American

o Native Hawaiian or Other Pacific Islander o White o Prefer Not to Answer

Please specify your ethnicity

o Hispanic o Non- Hispanic o Prefer Not to Answer

Emergency Contact:

Name:_____ **Relationship**:_____

Phone: Home ( )_____ Work ( )_____ Cell ( ) _____

Responsible Party/ Primary Insurance Carrier (If Not Self):

Name:_____ Date of Birth:_____ Age: _____

Address_____
Street Apt. # City State Zip

Phone: Home ( )_____ Work ( )_____ Cell ( ) _____

Employer:_____ Employer Phone: _____

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Please answer for HIPAA compliance (Privacy Act)

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine or voicemail? YES NO

May we send electronic copy of Continuity of Care Document (CCD) to your email? YES NO

With whom do you allow us to share your health information if you are unavailable?

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Advanced Care Plan

Do you have a Living Will?

Yes _____
No _____

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 (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (***please print***) Date

_____
Parent or Authorized Representative (if applicable)

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Boca Raton Podiatry of any changes to the above information.

Patient or Guardian Signature:_____ Date: _____

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BOCA RATON PODIATRY ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to Boca Raton Podiatry. This authorization is valid until I notify Boca Raton Podiatry in writing that it is revoked.

I understand that I am responsible for giving Boca Raton Podiatry the correct insurance information at the time services are rendered. Boca Raton Podiatry agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office, at time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for changes not covered by my Insurance due to my failure to obtain the required referral.

I authorize the release of medical information necessary to process my claim.

I agree to pay for non-covered services under my insurance plan (services for which I have policy exclusion).

I understand that Boca Raton Podiatry is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Boca Raton Podiatry expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10 re-billing fee for each additional statement sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a $25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there may be a $25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside agency that I shall be liable for all costs attorney of collection and any fees and or court costs incurred by this office.

I have read and understand the above policies.

_____

Patient or Patients Guardian or Legal Representative Signature Date

_____

Printed Name of Patient or Guardian or Legal Representative Relationship to Patient

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Patient Name _____

History & Medical Information

What is your Height:_____What is your Weight: _____

Past Medical History: (please circle all that apply)

Anemia	Gout	Kidney Disease	Other Arthritis
Bleeding Disorders	Heart Disease	Lung Disorders	Prostate Disorders
Cancer	Hepatitis	Mitral Valve Prolapse	Parkinson's
Diabetes	High Cholesterol	Nerve Disorders	Thyroid Disorders
Epilepsy	HIV/ Aids	Osteoarthritis	Stroke
Neurologic	High Blood Pressure	Other:_____	

List all Medications/herbs/vitamins:_____

_____

_____

What pharmacy do you use?_____Phone #: _____

Allergies/ Sensitivities: (please circle all that apply)

None Known	Sulfa Drugs	X-Ray Contrast/ Dyes	Shellfish
Penicillin	Aspirin	Other: _____	
Any Narcotics/ Codeine	Anesthesia	_____	

Have you ever had Surgery? (Please list any and all) YES NO

Describe: (surgery/ date): _____

_____

_____

Social History: (please circle all that apply)

Current Tobacco Use Y/N (how much?) _____ Past tobacco use Y/N Alcohol use Y/N

Caffeine Use Y/N Drug Use Y/N (recreational, IV) Are you pregnant? Y/N Nursing? Y/N

Exercise Habits _____

Family History: (list relationship of member(s) who have had problems)

	Mother	Father	Sibling
Arthritis			
Bleeding Disorders			
Cancer			
Diabetes			
Foot Problems:			
Gout			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stroke			
Other Family History			

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Patient Name _____

Review of Systems (circle all that apply)

1.Constitutional Symptoms:
Fevers Chills Sweats Weight Loss NONE

2. Cardiovascular:
Chest pain/ Heart Attack | Congestive Heart Failure | Heart Murmur | Palpitations
Swelling in Legs/ Ankles | Leg Pain w/ Exercise | Cardiovascular Surgery | NONE

3. Endocrine:
Often Thirsty | Often Urinating | Kidney Disease | Pancreatitis
Diabetes Mellitus | Prostate Problems | Thyroid Disorder | NONE

4. Head, Eyes, Ears, Nose, and Throat:

Wear:	Contacts	Dentures	Eyeglasses	NONE
Have:	Double Vision	Cataracts	Dizziness	NONE
	Difficulty Swallowing	Nose Bleeds	Sore Throat	
		Neck Pain	Ringing in the Ears	

5. Gastrointestinal:
Nausea | Vomiting | Diarrhea | Constipation | Stomach Ulcers
Decrease in Appetite | Blood in Stool | Hepatitis | Acid Reflux | NONE

6. Integumentary:
Rash | Skin Ulcers | Recurrent Infections | Cracking of the Skin
Change in Skin Color | Keloid | Hair Loss | NONE
Eczema | Lesions | Sensitivity of Skin

7.Hematological/ Lymphatic:
Bleeding | Swollen Glands | Lump in Groin or | Lymphoma
Abnormalities | Anemia | Armpit | NONE

8. Musculoskeletal:
Tendonitis | Bursitis | Broken Bones | Arthralgia
Weakness of Limbs | Feeling Weak | Joint Pain | NONE

9. Nervous System:
Migraines | Seizures | Strokes | Fainting
Ataxia (loss of balance) | Aphasia (loss of speech) | Confusion | NONE
Neuropathy (loss of sensation) | Speech Difficulties | Nervous Disorders

10. Psychiatric:
Nervousness | Tension | Depression | NONE

11. Respiratory:
Shortness of Breath | Wheezing | Bronchitis
Difficulty Breathing | Cough | Previous Pulmonary
Emphysema | Asthma | Disease
TB (tuberculosis) Exposure or Treatment | Pneumonia | NONE

**Please list any other medical concerns not listed above: _____

_____

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

Patient/ Guardian Signature:_____Date: _____

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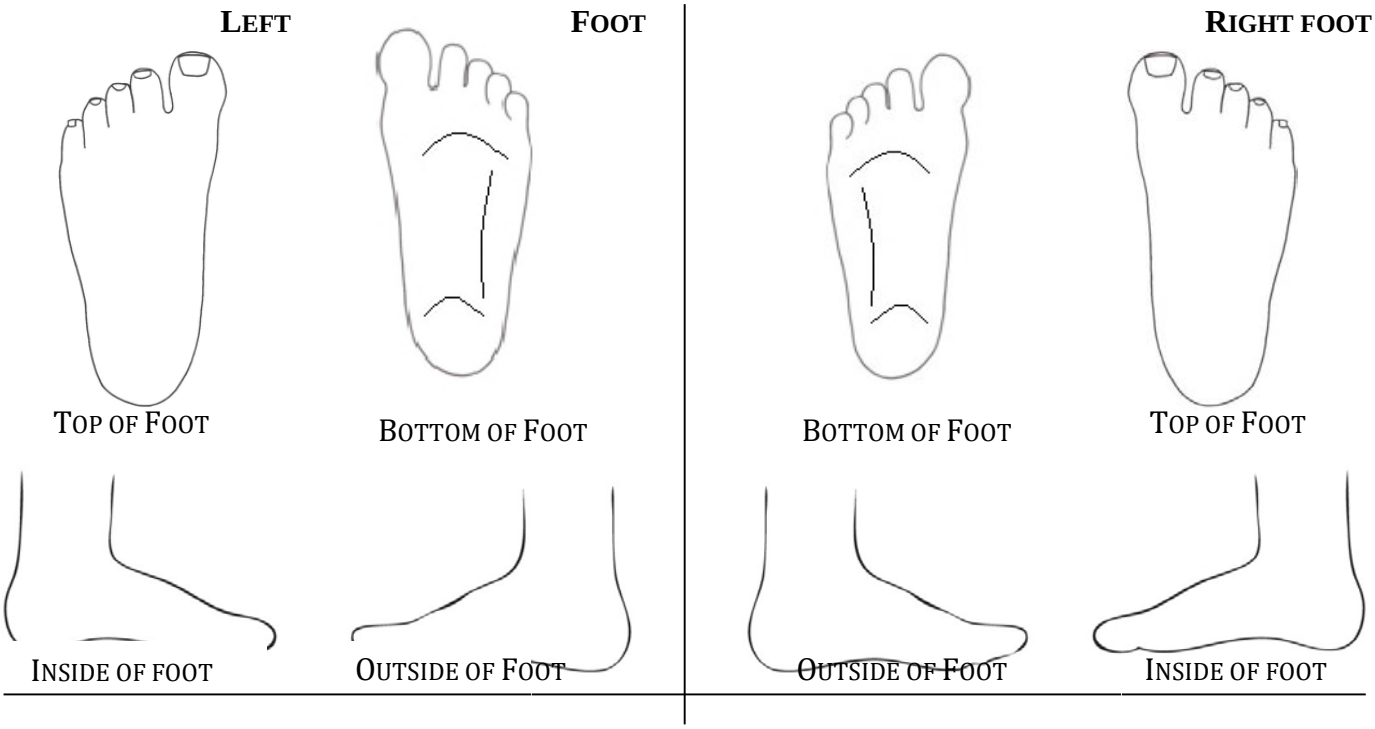
Patient Name: _____

CURRENT PROBLEM

What specific problem brings you to our office today? _____

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



How long ago did this problem first start?_____Days / Weeks / Months /

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other_____

How would you rate your pain on a scale from 0 to 10? (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ Stayed the same ☐ Become worse ☐ Improved

What makes your pain or problem feel worse?

☐ Walking ☐ Standing ☐ Daily activities ☐ Flat shoes ☐ Any closed toe shoe
☐ Resting ☐ Dress shoes ☐ High heels ☐ Running ☐ Other_____

What makes your pain or problem feel better?_____

What treatments have you had for this problem?_____

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

Was this problem caused by an injury? ☐ No ☐ Yes (describe)_____
If yes, was it a work-related injury? ☐ Yes ☐ No

Completed By:_____Date: _____