PGA Foot & Ankle P.A. **E. Charisse Dunn, D.P.M.**
*Board Certified in Foot Surgery
5610 PGA Blvd., Suite 212
Palm Beach Gardens, FL 33418
Phone: 561-776-7047
Fax: 561-776-7049

PERSONAL INFORMATION

Social Sec. #: _____ Sex: ( ) Male ( ) Female

Name: _____ _____ ___/___/___
(LAST NAME), (FIRST NAME) (MIDDLE INITIAL) (AGE) (BIRTHDATE)

Marital Status: __Single __Married __Widowed __Divorced __ Domestic Partner

Race: ( ) American Indian or Alaska Native ( ) Asian ( ) Black or African American
( ) Native Hawaiian or other Pacific Islander ( ) White

Ethnicity: ( ) Hispanic or Latino ( ) Non Hispanic or Latino

Address: _____

_____ _____ _____
City State Zip code

Telephone: (___) ____-_____ (___) ____-_____ (___) ____-_____
Home Office Mobile

Email Address: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Tel: ( ) ____-_____

PRIMARY CARE PHYSICIAN

Name: _____ Date of Last Visit: _____ Tel: ( ) ____-_____

PHARMACY INFO

Name: _____ Location: _____ Tel: ( ) ____-_____

EMPLOYMENT INFORMATION:
Occupation: _____

Employer Name: _____
Address: _____

INSURANCE INFORMATION : Please provide insurance card to receptionist

Whom may we thank for referring you to our office? _____

I have received and read the notice of privacy practices per HIPAA.

Signature _____ Date: _____
Patient/Authorized Person

-OVER PLEASE –

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Should you need assistance, please do not hesitate to ask our friendly staff. Thank you.

What is your foot or ankle problem? _____

_____

How long have you had this problem? _____ Have you had any prior treatment? _____

Have you injured your feet before, and if so, how? _____

_____

What type of work do you do? _____

Have you had foot treatment before? If yes, by whom? _____

Did anything disappoint you about your last visit to a Foot Specialist? _____

Have you had prior surgery of your foot and/or ankle? _____

Please list any other surgeries that you have had: _____

_____

What medications are you now taking? _____

_____

Height: _____ **Weight: _____** **Shoe Size & Width: _____**

Are you pregnant? ( ) yes ( ) no

Do you: Smoke (amount) _____ Drink Alcohol (amount) _____

Allergies: ( ) I am not allergic to anything to my knowledge ( ) I am allergic to (Please check)

__Aspirin __Penicillin __Sulfa __Novocaine other: _____
__Iodine __Codeine __Demerol __Adhesive _____

Please check appropriate places. I have, or have had the following:

__Alzheimer's
__Anemia
__Angina
__Anxiety
__Asthma
__Back Pain
__Bleeding Tendencies
__Cancer of (_____)
__Chemical Sensitivities
__Colitis
__Depression
__Diabetes
__Diverticulitis
__Fibromyalgia
__Glaucoma
__Gout
__Heart Murmur
__Heart Trouble
__Hepatitis
__High Blood Pressure
__High Cholesterol
__HIV
__Irritable bowel
__Kidney trouble
__Leg Cramps
__Migraines
__Osteoarthritis
__Osteopenia
__Osteoporosis
__Parkinson's Disease
__Phlebitis
__Prostate Problems
__Pulmonary Embolism
__Reflux
__Rheumatism
__Stomach Ulcers
__Stroke/TIA
__Thyroid Trouble

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PAYMENT POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are also eager to help you receive your maximum allowable benefit. We do, however, need your assistance and your understanding of our payment policy.

Payment is required at the time of service. We accept cash, checks, Visa and Mastercard. In the event that the courtesy of filing your insurance claim is extended to you, you must realize that all charges are your personal responsibility from the date services are rendered. Due to ever-changing health insurance laws and regulations, we cannot guarantee all services will be covered by your insurance policy. In the event that your insurance does not cover your services, you will be held responsible for payment.

Failure to pay bills will result in your account being referred to a collection agency and/or attorney. All collection and attorney fees, expenses and court costs will be the responsibility of the patient or the person responsible for the account.

A fee of $30.00 will be charged for any returned checks.

A fee of $25.00 will be charged for any appointments that are cancelled without 24 hours notice.

A fee of $ 14.00 per film will be charged for any duplication of x-rays.

If you have any questions concerning these policies or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Please sign below to indicate that you have read and understand this payment policy.

_____

Signature of Responsible Party

_____ _____

Patient Name Date

Acknowledgment of Privacy Practices

Patient Name: _____

I consent for Dr. Dunn, in a time of emergent need, to use video and conferencing technology, as a "telehealth" visit to:

1. Discuss and monitor an examination / procedure / treatment and diagnose and perform follow up during that visit.
2. The "telehealth" consultation will be similar to a routine office visit with the exception of an interactive video technology being used to communicate with Dr. Dunn at a distance.

I authorize Dr. Dunn to release information regarding my condition to the following people:

(Note: Include everyone's name and relationship that you are allowing for us to release information to including but not limited to: your spouse, child, relatives or friends.)

1. _____
2. _____
3. _____

***** In order to get results to you more quickly, may we leave normal results on your answering machine? Yes _____ No _____
Best number to leave a message (_____) _____

Our Notice of Privacy Practices ("Notice") provides information about the privacy rights of our patients, and how we may use and disclose protected health information about our patients.

Federal regulation requires that we give our patients or their authorized representatives ("you") the opportunity to review our Notice before signing this acknowledgment. A copy of our Notice is displayed in our office. A copy of our Notice will be made available to you upon your request.

By signing this form, you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

SIGNATURE: _____ _____
PATIENT/AUTHORIZED PERSON DATE

Confidential
PGA Foot & Ankle P.A.

PGA FOOT & ANKLE, P.A.

Photo Consent Form

Patient Name: _____ Date: _____

I consent for medical photographs to be taken of me by Dr. E. Charisse Dunn of PGA Foot & Ankle or a representative. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs, I understand that I will not receive payment from any party. These photographs will be used without identifying information, such as my name. I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of these images: (Please initial YES or NO below)

___Yes ___No For demonstration purposes including an office photo album

___Yes ___No On our website for prospective patients

___Yes ___No In print advertisements and/or professional journals

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

_____ _____
Printed Patient's Name Patient/Guardian's Signature

_____ _____
Printed Witness Name Witness Signature