FLORIDA FOOT & ANKLE ASSOCIATES

Pritesh Patel, DPM
900 NW 13th St, Suite # 106
Boca Raton, FL 33486
Tel: (561) 826-7032
Fax: (561) 826-8591

Patient Registration Form

Patient Name: _____ **Date of Birth:** _____
Last Name First Name Middle Initial

Social Security Number: _____

Home Address: _____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Mobile Phone:** _____ **Email Address**: _____

Employer Name: _____ **Work Phone:** _____

Occupation: _____ **Responsible for Payment:** _____

Demographics (required by Governmental Statistical Analysis)

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ I Decline to Report

Race: ☐ Asian ☐ American Indian ☐ Black /African American ☐ White ☐ Hispanic ☐ Other Race ☐ I Decline to Report

Primary Language: ☐ English ☐ Spanish ☐ Other_____

Emergency Contact: Name: _____ Relationship _____ Contact Phone: _____

Preferred Pharmacy: ☐ Costco ☐ CVS ☐ Publix ☐ Target ☐ Walmart ☐ Walgreens ☐ Other _____

Address _____ City_____ Zip _____ Phone Number: _____

Insurance Information:

Primary Insurance Company Name: _____

Policy Holder Name: _____ Date of Birth _____

Insurance Policy #: _____ Group #: _____

Secondary Insurance Company Name: _____

Policy Holder Name: _____ Date of Birth _____

Insurance Policy #: _____ Group #: _____

Privacy Information Preferences:

Can we send mail to the address on file ? ☐ Yes ☐ No

Can we call the phone number on file and leave voicemail on machine lab and diagnostic test results ? ☐ Yes ☐ No

Who can we leave message with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other _____

Name(s): _____ Name(s): _____

Please Read and Sign : The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

_____ _____ _____
Patient / Guardian Name (**please print**) Signature Date

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PATIENT HISTORY WORKSHEET

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

Sex: ☐ M ☐ F **Height:** _____ **Weight:** _____ **Shoes Size:** _____ **Width:** _____

Primary Care Doctor: _____ **Last Visit:** _____ **Hgb A1C** (Diabetics): _____

Referred By: Dr._____ Friend/Relative _____ ☐ Google ☐ Insurance ☐ Other_____

Reason for today's visit: _____

How long ago did this problem first start? [1,2,3,4,5,6,7] _____ ☐ Days ☐ Week ☐ Month ☐ Years

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

How would you describe your pain:

☐ Aching ☐ Burning ☐ Dull ☐ Itching ☐ Radiating ☐ Stabbing ☐ Sharp ☐ Throbbing ☐ Tingling ☐ Other _____

How would you rate your pain on a scale from 1 to 10?

☐ 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 ☐ Resting ☐ Dress Shoes

☐ High Heels ☐ Flat Shoes ☐ Any Close Toe Shoes ☐ 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 work - related injury: ☐ No ☐ Yes **, Date of injury at work** _____

ALLERGIES

☐ Adhesives tape ☐ Cipro ☐ Cortisone ☐ Iodine ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa drugs

☐ Aspirin ☐ Codeine ☐ Demerol ☐ Latex ☐ Metals ☐ Shellfish ☐ Other _____ ☐ **NONE**

Type of Allergies Reaction: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Alcohol Intake: ☐ No ☐ Occasionally /Socially ☐ Yes # drinks/week _____

Tobacco Use: ☐ No ☐ Quit _____ year ago ☐ Yes # pack/day _____ For _____ year

Recreational Drugs Use: ☐ No ☐ Yes type of drugs: _____

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Daily ☐ Weekly ☐ Several time a week

PAST SURGERIES (only last 5 years)

Type of Surgeries Date

_____

_____

_____

☐ Appendectomy ☐ C- section ☐ Angioplasty ☐ Bypass

☐ Cataracts ☐ Cholecystectomy

CURRENT MEDICATIONS

Name Dose

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

☐ Anemia	☐ Blood Clot /DVT	☐ Gout	☐ Liver Problem	☐ Skin Disorder
☐ Anxiety	☐ Cancer Type_____	☐ Heart Problem	☐ Lung Disease	☐ Stomach Ulcer
☐ Arthritis	☐ Diabetes type ☐ 1or ☐ 2	☐ Hepatitis A/B/C	☐ Migraines	☐ Stroke/TIA
☐ AIDS/HIV	☐ Dialysis	☐ High Blood Pressure	☐ Osteoporosis	☐ Thyroid Disorder
☐ Artificial Heart Valve	☐ Ear Problem	☐ High Cholesterol	☐ Phlebitis	☐ Varicose Veins
☐ Back Pain	☐ Epilepsy	☐ Leg Cramp	☐ Pneumonia	☐ **NONE**
☐ Bleeding problem	☐ Fibromyalgia	☐ Kidney Problem	☐ Sciatica	

FAMILY HISTORY

☐ Arthritis ☐ Cancer ☐ Coronary Artery Disease ☐ Diabetes Type 1 or Type 2 ☐ Heart Disease ☐ High Blood Pressure ☐ Neurological ☐ Stroke ☐ Thyroid Disease ☐ **NONE**

REVIEW OF SYSTEM

(Please check the box if you currently have any of these symptoms or check "NONE")

Constitutional Symptoms

☐ Fevers ☐ Chills ☐ Sweats ☐ Weight Loss ☐ **NONE**

Cardiovascular:

☐ Leg pain when walking ☐ Fever ☐ Chest Pain/Pressure ☐ Leg Swelling ☐ Cold Hands/Feet ☐ Fainting

☐ Fainting ☐ Palpitation ☐ Vascular Disease ☐ Valve Problem ☐ **NONE**

Gastrointenstinal

☐ Abdominal pain ☐ Heartburn ☐ Blood in Stools ☐ Vomiting ☐ Ulcers ☐ Constipation

☐ Diarrhea ☐ Trouble swallowing ☐ Decrease appetite ☐ Increase Appetite ☐ **NONE**

Genitourinary

☐ Blood in Urine ☐ Decreased Frequency ☐ Incontinence ☐ Increase Urgency ☐ Hesitancy

☐ Excessive Urination ☐ Kidney Disease ☐ Kidney Stones ☐ **NONE**

Hematologic

☐ Lower Leg Ulcers ☐ Sickle cell disease ☐ Anemia ☐ Blood Thinners ☐ Clotting Disorders ☐ **NONE**

Integumentary

☐ Athletes foot ☐ Nail Abnormalities ☐ Keloids ☐ Itchiness ☐ Dry, Scaly Skin ☐ **NONE**

Neurological

☐ Tingling ☐ Weakness ☐ Seizures ☐ Numbness ☐ Headaches ☐ Tremors ☐ Paralysis ☐ **NONE**

Musculoskeletal

☐ Back pain ☐ Joint Swelling ☐ Muscle Weakness ☐ Muscle Pain ☐ Neck Pain

☐ Sciatica ☐ Joint Stiffness ☐ Joint Pain ☐ Joint Instability ☐ Arthritis ☐ **NONE**

Respiratory

☐ Chest Pain ☐ Wheezing ☐ COPD ☐ Coughing ☐ Snoring ☐ Shortness of Breath ☐ Emphysema ☐ **NONE**

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 month ? ☐ Yes ☐ No **If yes, were you injured from the fall?** ☐ Yes ☐ No

Patient/Guardian Name: _____ Signature: _____ Date: _____

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Financial Responsibility and Payment Authorization

I certify that I am the guarantor for any bills affiliated to the above-named patient with the office Florida Foot and Ankle Associates, LLC (FFAA) and that I am fully liable for any and all treatment expenses / open balances, even if my insurance carrier fails to comply or remit payment to the physician's office.

I understand that I am responsible for the payment of Co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by my insurance. I understand that it is my responsibility to obtain pre-authorization by my insurance carrier prior to my visit or any additional procedures that must be taken by the physician.

I understand that I may be charged interest on any and all outstanding balance(s) left on my file by me the patient. I understand that if it is necessary, I will be reported to collection bureaus regarding any outstanding debt and that I will not only be liable for the initial bill, but in addition any collection fees, litigation fees, or attorney fees affiliated with my file. I understand and give permission to the office of FFAA to retain copy of my driver's license and Social Security card for security reasons.

I understand that any non-sufficient funds or closed account checks presented to this office will be turned over to the state attorney for possible criminal prosecution and I will be responsible for returned check fees $40 for all returned checks. I authorize payment by my insurance company to FFAA and authorize release of any medical information necessary to process my claims.

I also understand that I will be considered a NO SHOW if I miss an appointment and do not notify office at least 24 hours advance notice prior to appointment. I will receive a bill of $35 if I Reschedule, Cancel or No show more than one appointment per year. Payment to be made via cash or credit card or check at the time of your next follow-up appointment.

DME products such all splints, ace bandages, shower bags, stocking, walking boot, post-op shoes, cream, lotions and orthotics dispensed are non-refundable. Patients are required to provide the most current and updated information about their insurance coverage

I understand, I am responsible for obtaining the proper referrals needed to seek treatment in this office. Please contact your insurance carrier if you are unsure if a referral is required. You will be responsible for the balance due if your insurance company denies a claim when a required referral is not obtained prior to your visit.

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Consent for Treatment: I, the patient, legal guardian or health care surrogate voluntarily consent to the tendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Release of Information: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or family member or employer of the patient for all or part of the physician(s) charges, including but not limited to Insurance companies, Worker's Compensation carriers, welfare funds, or the patient's employer.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of you revocation. Please understand that revocation of this consent will NOT affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

Medicare and Medicaid Patient Certification- Patient's certification Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title VII and/or Title XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carrier, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductible, co-pay, and co-insurance.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I acknowledge that I was provided a copy of Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and I understood the Notice of Privacy Practices of Florida Foot and Ankle Associates LLC.

I have read the entire above page and understand it.

Patient / Responsible Party (**please print**)	Signature	Date

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RELEASE OF MEDICAL RECORDS

Re: Request for privacy/release of medical records:

_____ _____
(Patient Name) (DOB)

To Whom It May Concern:

I am writing to request and authorize the release of my medical records that are in your possession to Dr. PRITESH PATEL.
Fax: (561) 826 - 7032 .

If you receive any other request or demand for medical records, please let me know promptly.

I also request that you place this letter in my medical records file.

Sincerely,

_____ _____
Patient's Signature Date