Integrative Foot & Ankle Centers

DR. DANIEL PERO
P (561) 293-3439 F (561) 689-1844
www.integrativefoot.com
West Palm Beach • Loxahatchee • Palm Beach Gardens

PATIENT INTAKE FORMS

Name: _____ **DOB:** _____

Sex (Please Circle): M or F **Marital Status** (Please Circle): Single, Married, Widowed, Divorced

Home#: _____ **Cell#:** _____ **Other#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Email: _____ **Spouse/Partner Name:** _____

Employer: _____ **Employer Phone#:** _____

Emergency Contact: _____ **Phone#:** _____

How did you find out about our practice (Circle One): Physician, DanielPero.com, Integrativefoot.com, Google, Family Member, Other: _____

Reason For your visit today: _____

Was it a result of accident or work injury (Circle One): Yes or No

How long has this been bothering you: _____

What treatments have you tried and were they effective: _____

On a scale of 1-10 (1 being no pain 10 being the worst) what is your level of pain: __/10

The pain quality is (Circle all that pertain): Burning, Constant, Dull, Sharp, Shooting, Throbbing, Tingling

Other: _____

Please read and Sign: The above information is correct to the best of my knowledge. I understand 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 Signature: _____ Date: _____

Name: _____ **DOB:** _____

Ethnicity (Circle one): Hispanic or Latino Not Hispanic or Latino Decline to Specify

Race (Circle one): White Asian American Indian or Alaska Native Black or African American

Native Hawaiian or other Pacific Islander Decline to specify

Preferred Language: _____

Pharmacy Name: _____ **Pharmacy Phone#:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

PRIVACY INFORMATION PREFERENCES (Please circle)

Do you want to be exempt from public reporting? Yes or No

Can we send mail to address on file? Yes or No **Can we call the phone number on file?** Yes or No

Can we leave a voicemail on the machine? Yes or No

Can we send you email reminders/newsletters? Yes or no

Who can we leave messages with: Wife Husband Daughter Son

Name(s): _____

Name: _____ **DOB:** _____

SMOKING STATUS (PLEASE CIRCLE ALL THAT APPLY)

Current Every Day Smoker, Current Status Unknown Current Some Day Heavy Tobacco

Unknown If Ever Former Never Light Tobacco Decline to Answer

CURRENT MEDICATIONS (CIRCLE ONE)

No Known Medications I take the following Medications:

Name / Dose: _____ **Name / Dose:** _____

Name / Dose: _____ **Name / Dose:** _____

Name / Dose: _____ **Name / Dose:** _____

Name: _____ **DOB:** _____

ALLERGIES (CIRCLE ONE)

No Known Allergies No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ Did you get a pneumococcal vaccination: Yes or No

Have you fallen in the last 12 months? Yes or No Were you injured from the fall? Yes or No

Advanced Directives (Circle One): Living Will DNR Durable Power of Attorney
Surrogate Appointed None

PLEASE READ AND SIGN: The information on my intake forms 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. (*Assignment of Benefits):* I authorize payment of medical benefits to the practice named above. (*Release of Information*): I authorize the release of any medical information necessary to process this claim. (*HIPAA PRIVACY*): I acknowledge that I received my HIPAA Privacy Practice Notice. (*Medication History*): I authorize the Doctor's office to retrieve my mediation history.

Patient Signature: _____ **Date:** _____

Name: _____ **DOB:** _____

HISTORY AND PHYSICAL

Medical History (Please Circle All That Apply):

Liver *Heart Murmur* *Blood Clot* *Neuropathy (specify)* _____ *Arthritis (specify)* _____

Alcoholism *Sleep apnea* *Stomach/bowel* *High Cholesterol* *Blood Disorders* *Gout*

Thyroid Disease (specify) _____ *Circulation Problems* *Allergies* *Anxiety Disorder*

High Blood Pressure *Musculoskeletal* *Heart Disease* *Mental Illness* *Cancer* *HIV*

Diabetes (type1, type 2) *Skin Disorders* *Breathing Issues* *Asthma* *Kidney Disease* *Hepatitis*

CVA *Stroke* *Other (Specify)* _____ Are you pregnant? Yes or No Are you nursing? Yes or no

Surgical History (Please Circle all that Apply):

None *Appendectomy* *C-Section* *Angioplasty* *Bypass* *Cataracts* *Cholecystectomy*

Have you ever had any surgical procedure on your foot/ankle or any other body part? *Yes or No*

Social History

Do you smoke? Yes or No If yes, How many packs per day? _____ For how long? _____

Do you drink alcohol? Yes or no If yes, How often: Everyday Occasionally Rarely

Substance Abuse: Yes, I have a substance abuse problem. Please Specify _____

No, I never had a substance abuse problem

What is your occupation? _____ Does it involve mostly? Standing or Sitting

Do you exercise regularly? Yes or no If yes, what kind of exercise? _____

Family History *Is there any family history (blood relative) of: (Please indicate family member)*

Alzheimer's _____

Arthritis _____

Bleeding Disorders _____

Blood Clot _____

Cancer _____

Cataracts _____

Circulation Problems _____

Depression _____

Diabetes _____

Emphysema _____

Heart Disease _____

High Blood Pressure _____

Neurological _____

Strokes _____

Other (Please Specify) _____

Review of Systems (Please circle if you currently have any of these symptoms or circle "NONE")

Cardiovascular: *Shortness of Breath Fever Chest pain/pressure Fainting palpations vascular disease valve problems NONE*

Genitourinary: *Blood in Urine Hesitancy Incontinence Increased Urgency Decreased frequency Excessive Urination Kidney Disease Kidney Disease Kidney Stones NONE*

Gastrointestinal: *Abdominal Pain Heartburn Blood in Stool Vomiting Ulcers Constipation Diarrhea Trouble Swallowing Decrease Appetite Increase Appetite NONE*

Integumentary: *Athletes Foot Nail Abnormalities Keloids Itchiness Dry, Scaly Skin NONE*

Hematologic: *Lower Leg Ulcers Sickle Cell Disease Anemia Blood Thinners Clotting Disorder 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 Knee pain Flat Feet Hip Pain*

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

Vascular: **Veins LEG–** *aching/pain Heaviness Bulging varicose veins fatigue Spider veins Itching/burning Swelling Cramps/Throbbing Restless Legs Non-healing wounds*

Arterial - *Leg pain/cramping when walking Leg numbness or tingling Cold feet Toes Pale or Discolored Leg Sores High Blood Pressure Strokes Diabetes*

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 Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you or by your health insurance carrier, payments for office services are due at the time of service. We accept VISA, Mastercard, Discover, cash or check
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance pay the doctor directly. If your insurance company does not pay to the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans t accept an assignment of benefits. We will bill those plans with which we an agreement and will only require you to pay the co-pay/ co-insurance/ deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All the health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered.
- You must inform the office of all insurance changes and authorizations/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In the t even, payment will be due on e week prior to surgery.
- Past due accounts are subject to collection proceedings. All cost incurred, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $30.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/ Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____

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HIPAA PATIENT STATEMENT

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you my mail or phone at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we man mail you a post card reminding you to make an appointment and we may leave a message for you on any answering devises or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:

You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requestee amendment. We will notify you as to whether we agree or disagree with the requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures that we make to you, to carry out treatment, payment or healthcare operations, as requested by you written authorization, as permitted or required under 45 CFD 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with your practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient of Legal Guardian: _____ **Date:** _____

Print Name of Patient or Legal Guardian: _____

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RELEASE OF MEDICAL INFORMATION

Permission to get records:

I, _____, with a date of birth, _____, give my permission for
(patient name) *(patient's DOB)*
_____ to give my medical records (as described on pg. 2) to
(Doctor or hospital name who has records)
_____so that he/she can better understand my condition and help me.
(my doctor's name)

I understand that:

- I do not have to give my permission to share these records.
- If I want to take away the permission for my doctor to get these recordsd, I need to talk to the doctor or a staff person and sign a paper.
- This form is only good for 3 months from the date I sign it.

Patient Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Relationship of Authorized Representative: _____