Dr. Maurice W. Aiken
Bay Breeze Foot & Ankle Specialists, P.L.L.C.
1022 Main St. Suite L, Dunedin, FL 34698
Phone (727) 734-5575 • Fax (727)733-4147
www.BayBreezeFeet.com

Patient Name: (Last, First, Middle) _____

Local Address: _____
Street City State Zip +4

Permanent Address: (If different) _____

Date of Birth: _____ Age: _____ Social Security #: _____ Full Time Student ☐Y ☐N

Race: ☐ Am Ind or AK Nat ☐ Asian ☐ Blk or Afr Amer ☐ Nt HI or Ot PA Is ☐ White ☐ Declined

Ethnicity: ☐ His or Latino ☐ Not His or Latino ☐ Declined

It is our practice to call or e-mail appointment reminders. It may also be necessary for our office to contact you for purposes of detailed medical and financial information. I authorize the practice to contact me by the following:

Home phone (____) _____ Cell (____) _____ Fax (___) _____

Employer: _____ Occupation: _____ Work phone(____) _____

E-Mail Address: _____ Ok to leave a message on answer machine: ☐Y ☐N

Please list any restrictions concerning your being contacted at the above numbers:

_____

Name of Spouse/Parent/Other Emergency Contact: _____

Telephone: #1 (____)_____ #2 (____)_____ Relationship: _____

How did you select our office? (Please check all that apply) ☐ Primary Dr ☐ Insurance

☐ Location/Sign ☐ Internet ☐ Yellow Pages ☐ Friend or ☐Family Name: _____

Name of Primary Physician: _____ Phone: _____

Name of Cardiologist: _____ Phone: _____

Name of Endocrinologist: _____ Phone: _____

Pharmacy Name/Location: _____ Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Only the disclosed insurances will be billed. It is the patient's responsibility to notify us of any changes to their insurance or policy benefits. Does your insurance require a referral: ☐Y ☐N

I hereby authorize Bay Breeze Foot & Ankle Specialists, PLLC, to release any information acquired in the course of my examination or treatment, that photocopies of this form will be as valid as the original, and that medical photographs may be taken in the course of treatment. Payment is expected when services are rendered, unless other arrangements are made in advance. I hereby authorize payment directly to Bay Breeze Foot & Ankle Specialists, PLLC, of the amount due me in my pending claim for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me.

Date: _____ Signature of Patient or Legal Guardian: _____

If Not Patient, Relationship and Printed Name: _____

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1. Please describe the reason for your visit today:

_____

_____

2. Please give the location of your symptoms: (example – right great toe, left heel, etc.)

_____

3. Approximately when did the symptoms start:

_____

4. Was the onset of symptoms: ☐ gradual or ☐ sudden ☐trauma related or ☐work related

5. Describe your pain:

☐ burning ☐ stinging ☐ throbbing ☐ aching ☐ numbness

☐ worse in a.m. ☐ worse in p.m. ☐ time of day not a factor

☐ worse at rest ☐ comes and goes ☐ worse when standing or walking

☐ getting worse ☐getting better ☐ about the same since onset

☐other: _____

6. Describe any influencing factors such as previous surgery, possible injury, or accident:

_____

_____

7. Have you seen another doctor for this condition?

☐ Primary Doctor ☐Podiatrist ☐ Orthopedic ☐ Other: _____

Were X-rays taken: ☐ YES ☐ NO

8. What were their recommendations for the care and how did the condition respond?

_____

_____

9. Please describe any home remedies or treatment, and indicate if they were of help or not:

_____

10. Please describe any family member's similar foot problems , and list their relationship to you:

_____

11. If you have ever seen a podiatrist, had childhood foot problems, or previous surgery, please list the date and give details:

_____

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☐ **Please check if on no medications or herbal supplements**

Note: If you are on more medications/supplements then space provided below, add as many as space permits and bring remaining list or medications to the office

Medications (Please list prescriptions and over the counter medicines you take)	Size (i.e. mg, tsp.)	Take (number)	Frequency (i.e. daily, every 4 hours)	Route (i.e. oral, inject)

☐ **No Known Allergies**

Allergies - Please check known allergies and describe the reaction

√	Medication	Reaction (i.e. rash, fever, vomiting, GI upset, hives)
	Penicillin	
	Aspirin	
	Demerol	
	Codeine	
	Sulfa	
	Tetanus	
	Tape	
	Iodine	
	Local Anesthetics	
	Other:	

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Past Medical History: Chronic or Serious Illnesses
(Please check all that you have a history of)

☐ Anti-Coagulation Therapy (Coumadin)
☐ Arthritis, Rheumatoid
☐ Arthritis, Osteo
☐ Asthma
☐ Back Pain
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Depression/Anxiety
☐ Diabetes, Type I
☐ Diabetes, Type II
☐ Glaucoma
☐ Gout
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Peripheral Vascular Disease
☐ Phlebitis
☐ Respiratory Disorders (COPD, Emphysema)
☐ Stomach Ulcers
☐ Other: _____

Major Surgeries / Operations: (please indicate approximate year)

☐ Angioplasty yr:_____
☐ Appendectomy yr:_____
☐ Cholecystectomy (gallbladder) yr:_____
☐ Heart Stents/Open Heart yr:_____
☐ Hernia Umbilical/Inguinal yr:_____
☐ Hysterectomy yr:_____
☐ Joint Replaced (hip___ knee___) yr:_____
☐ Lung Surgery yr:_____
☐ Mastectomy yr:_____
☐ Thyroidectomy yr:_____
☐ Tonsillectomy yr:_____
☐ Vascular yr:_____
☐ Other yr:_____
_____

Social History

Marital/Children Status: ☐ Single ☐ Married ☐ Widow ☐ Divorce #___ Boys # ___ Girls ☐ No Children

Exercise: ☐ None ☐ Occasional Walking ☐ Regular Walking #____Miles/Week
☐ Running #____Miles/Week ☐ Gym Workout #____Times/Week
☐ Swimming ☐ Biking #____Miles/Week
☐ Other _____

Alcohol: ☐ None ☐ Former Drinker ☐ Rare ☐ Social #_____ drinks per day

Smoking: ☐ Never ☐ Former Smoker ☐ Current Smoker # _____ packs per day

Family History

Mother: ☐ Alive ☐ Deceased Father: ☐ Alive ☐ Deceased

Siblings: #_____ Brothers #_____ Sisters ☐ No Siblings

Please check all that you have a family history of:

☐ Alcoholism
☐ Arthritis
☐ Cancer (type)_____
☐ Depression
☐ Diabetes
☐ Gout
☐ Heart Disease
☐ Hypertension
☐ Stroke

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Review of Systems

Do you currently have or are you being treated for:

General

Fever or chills	☐No	☐Yes
Unexplained weight loss	☐No	☐Yes

Eyes

Visual changes	☐No	☐Yes
Eye pain	☐No	☐Yes

Ears

Hearing loss	☐No	☐Yes
Ear pain	☐No	☐Yes

Nose / Mouth / Throat

Nasal congestion	☐No	☐Yes
Mouth lesions	☐No	☐Yes
Sore throat	☐No	☐Yes
Difficulty swallowing	☐No	☐Yes

Cardiovascular

Chest pain or palpitations	☐No	☐Yes
Lower extremity edema or swelling	☐No	☐Yes
Experience thigh or leg pain when walking distances	☐No	☐Yes

Respiratory

Cough	☐No	☐Yes
Shortness of breath	☐No	☐Yes
Wheezing	☐No	☐Yes

Gastrointestinal

Diarrhea	☐No	☐Yes
Nausea	☐No	☐Yes
Constipation	☐No	☐Yes
Blood in stools	☐No	☐Yes
Abdominal pain	☐No	☐Yes

Musculoskeletal

Back pain	☐No	☐Yes
Joint pain or swelling	☐No	☐Yes
Muscle pain	☐No	☐Yes

Skin

Rash	☐No	☐Yes
Bothersome skin lesions	☐No	☐Yes
Slow healing wounds	☐No	☐Yes

Neurological

Headaches	☐No	☐Yes
Numbness or tingling	☐No	☐Yes
Gait instability	☐No	☐Yes
Difficulty Speaking	☐No	☐Yes
Confusion	☐No	☐Yes
Seizures	☐No	☐Yes

Psychiatric

Anxiety	☐No	☐Yes
Depression	☐No	☐Yes

Hematologic / Lymphatic

Easy bruising or bleeding	☐No	☐Yes
Swollen glands	☐No	☐Yes

Allergic / Immunologic

Itchy / watery eyes	☐No	☐Yes
Recurrent infections	☐No	☐Yes

Endocrine

Frequency in urination	☐No	☐Yes
Sweating	☐No	☐Yes
Excessive thirst	☐No	☐Yes
Cold / heat intolerance	☐No	☐Yes

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Summary Of Notice Of Privacy Practice

Privacy Officer: Karen T.

This summary is provided to help you understand the Notice of Privacy Practices and describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully; the privacy of your medical information is important to us.

OUR LEGAL DUTY: We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it. Copies of our complete notice of privacy practices, which contains a detailed description of how our office will protect your health care information, are located in the reception area and each treatment room. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION: We will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training.

USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION: Except as stated in more detail in the notice of privacy practices, we will not use or disclose your health information without your written authorization.

USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION: In the following circumstances, we may disclosure protected health or financial information without your written authorization: To family members or close friends who are involved in your health. For certain limited research purposes. For purposes of public health and safety. To government agencies for purposes of their audits, investigations, and other oversight activities. To government authorities to prevent child abuse or domestic violence. To FDA to report product defects or incident. To law-enforcement authorities to protect public safety or to assist in apprehending criminal offenders. When required by court orders, search warrants, subpoenas, and as otherwise required by the law.

AS OUR PATIENT YOU HAVE THE FOLLOWING RIGHTS: To have access to and or a copy of your health information. To receive an accounting of certain disclosures we have made of your health information. To request restrictions as to how your health information is used or disclosed. To request that we communicate with you in confidence. To request that we amend your health information. To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our detailed Notice of Privacy Practices or contact a staff member.

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Privacy Practices

Patient's Name (Please Print): _____ Date of Birth: _____

All signatures below are the patient's unless the patient is unable to understand or sign. If a legally authorized representative is signing for the patient, please also print name and state relationship. By signing each section you are stating you fully understand and agree to that section of this document.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Bay Breeze Foot & Ankle Specialists prior to my signing this, and that I have read or had the opportunity to read if I so choose and understand the notice.
Patient Signature: _____ Date: _____

Consent for Medical and Billing Records Access

I allow (Patient Designee) _____ (Relationship) _____
to have access to my medical records.
Patient Signature: _____ Date: _____

Financial Policy

An insurance policy is an agreement between you and your insurance company. Payment for services rendered and reimbursement from the insurer is ultimately the responsibility of the patient. If your insurance company requires a referral, it is your responsibility to obtain the necessary referrals for each visit. If we do not participate in your plan, payment is expected when services are rendered. Copays, deductibles and charges for non covered services are due at time of visit. Interest may be added to past due accounts in the amount of 1.5% monthly. If your account is sent out for collection, you will be responsible for any additional collection costs and attorney fees that may be incurred, including past due interest charges and a late payment service charge.
Patient Signature: _____ Date: _____

Medicare & Commercial Insurance Assignment of Benefits

I request that payment of authorized Medicare/Commercial benefits be made directly to me or on my behalf to Bay Breeze Foot & Ankle Specialist, PLLC, for any services or products furnished me by its physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits, or the benefits payable for related services.
Patient Signature: _____ Date: _____

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Financial Policy

Patient: _____ DOB:_____

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 your health insurance carrier, payment for office services are due at the time of service. We will 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 company pay the doctor directly. If your insurance company does not pay 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 to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay / co-insurance / deductible.
- 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 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. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided 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 that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, 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.
- Patients will be charged a FEE for any missed appointment that does not receive a 24 hour cancellation notice.

Signature of Patient/Responsible Party: _____Date:_____

Printed Name of Patient/Responsible Party: _____

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at BAY BREEZE FOOT & ANKLE SPECIALISTS it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with BAY BREEZE FOOT & ANKLE SPECIALISTS to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Patient Signature _____ Date _____

Patient Name Printed _____