**Integrative Foot & Ankle Centers**

**DR. DANIEL PERO**

**P (561) 293-3439    F (561) 689-1844**

***www.integrativefoot.com***

**West Palm Beach**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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)**

**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

**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?

**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*

**­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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

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

Alzheimer’s \_\_\_\_\_\_\_\_\_\_\_\_\_ Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emphysema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Clot \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Neurological \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circulation Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strokes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 records, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **PERIPHERAL ARTERIAL DISEASE QUESTIONAIRE**

|  |  |  |
| --- | --- | --- |
| 1. Do you experience aching, cramping or pain in your legs, thighs or buttocks when you walk or exercise?

If yes, does the pain subside with rest |  YES | NO |
|  1. Do you have numbness and tingling in the lower legs and feet?
 |  YES | NO |
| 1. Are your toes pale, discolored or bluish?
 |  YES | NO |
| 1. Are your feet cold to the touch?
 |  YES | NO |
| 1. Do you have any sores or ulcers on your legs or feet that don’t heal?
 |  YES | NO |
| 1. Do you have any difficulty controlling your blood pressure on more than 3 blood

 pressure medications? |  YES | NO |
| 1. Do you have a personal history of high blood pressure, diabetes or aortic aneurysm?
 |  YES | NO |
| 1. Do you have a family history of high blood pressure, diabetes or aortic aneurysm?
 |  YES | NO |
| 1. Have you ever experienced a stroke, mini-stroke or transient ischemic attack (TIA)?
 |  YES | NO |
| 1. Do you experience aching, cramping or pain in your legs when you are sleeping?

 If Yes, does it subside when you get up and walk around? |  YES | NO |