2022 Patient Intake Form

Your first appointment to our practice establishes a vital foundation for our medical relationship. The initial visit requires we obtain important information about your medical history. Please take the time to complete your forms in advance and bring them to your first appointment. This helps us to limit your wait time and enables us to run on schedule.

WE HAVE A 24 HOUR CANCELATION AND NO-SHOW POLICY! THE CURRENT FEE IS $ 50.00

Mission Statement
Our practice is working together to realize a shared vision of uncompromising excellence in podiatric care.

To fulfill this mission, we are committed to:

- Earn the trust and respect of patients, profession and community.
- Exceed your expectations.
- Strive for continuous improvement at all levels.

Feel free to go to our website for a wealth of information that may be helpful to you.

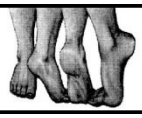
OUR OFFICE IS LOCATED AT:
820 EAST HILLSBORO BLVD.
DEERFIELD BEACH, FL 33441

www.eastoceanpodiatry.com

Directions:

We are **TWO** short blocks **WEST** of Federal Highway (US 1) and **ONE** block **WEST** of the Deerfield Beach Fire station. We are also **TWO** blocks **EAST** of Lane Tullis Road and **ONE** half mile **EAST** of Dixie Highway. If you pass over Federal Highway heading **EAST** you have gone too far!!!

Please download the small map of our office for a better look at where we are located.



EAST OCEAN PODIATRY **PATIENT DEMOGRAPHICS**

We are asking for your race and ethnicity because some people have higher risks of developing certain disease, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care.

Please fill in the information below. We greatly appreciate your participation. Thank You in advance

PATIENT NAME: _____

Race. Please mark what best describes you.
(Please mark only ***ONE*** race.)
□ American Indian/ Alaska Native
□ Asian
□ Black/ African American
□ Native Hawaiian/ Pacific Islander
□ White/ Caucasian

Language. Please mark what best describes you.
(Please mark only ***ONE*** primary language.)

□ English □ Spanish
□ French □ Russian
□ Italian □ Dutch
□ Chinese □ Japanese

Are you of Hispanic Origin?
(Please mark ***ONE*** statement that best describes you.)

□ Hispanic or Latino
□ No, not Hispanic/ Latino
□ I prefer not to answer

Please Check ***ANY*** that apply to you.

Specific Allergies: □ Baker's Yeast □ Eggs □ No

Could ***you*** be pregnant? □ Yes □ No

Are ***you*** a smoker? □ Former □ Never □ Current

Do ***you*** have any terminal illnesses? □ Yes □ No

To provide you with the best care, we are now able to provide you with your medical records online and also electronically prescribe your medications. To be able to do so we Need your cooperation in providing us with your e-mail and pharmacy information. If you do not know the exact address or phone number to your pharmacy please provide the pharmacies cross streets.

Patient E-mail: _____

Preferred Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Pharmacy Address: _____
(or cross streets) _____

Patient Signature: _____ Date: _____

Please thoroughly read each East Ocean Podiatry policy, initial next to each policy and sign below:

Treatment Agreement

_____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

_____ For the purpose of payment, I allow **East Ocean Podiatry** to release my Private Health Information to any and all of my insurance carriers, their third payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all my treating physicians.

_____ I promise to provide complete and accurate information to the doctors about my health and medications, including over the counter products. I also understand my responsibility to be respectful of the doctors, staff and other patients.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The HIPAA rights are also posted in the lobby and at **www.eastoceanpodiatry.com.**

Patient Financial Policy

_____ You must provide personal (address, phone numbers, etc) and/or insurance changes (carriers, networks, id numbers, etc.) to the office prior to your appointment.

_____ You are responsible for **all authorizations/referrals/precerts** needed to seek treatment with **East Ocean Podiatry's** physicians.

_____ Your portion of payment for ALL office services is due **at the time of service.** We will accept VISA, MasterCard, 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. When you do an assignment of benefits, you are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

_____ Please honor our 24 hours reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.

_____ We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and **will require you to pay the co-pay/co-insurance/deductible at the time of service.** If you are seeing our doctors on a "Out of Network" basis, you will be subject to out of network rates.

_____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services: however, you remain responsible for charges to any service rendered. **Patient are encouraged to contact their plans for clarification of benefits prior to services rendered.**

_____ Our office does not file secondary insurance, unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your **designated** PRIMARY policy.

_____ Pre-scheduled Surgical procedures require pre-payment/estimated deposit. **Your deductible/co-pay for this procedure is due at the pre-operative appointment.** For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility. There is a $100.00 no refundable clerical fee for surgeries not cancelled two weeks in advance. We suggest you carefully select your surgical date to avoid this charge. It is your responsibility to obtain an adult to transport you to and from surgery and remain with you for 24 hours.

_____ PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

_____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the **East Ocean Podiatry** relationship.

_____ There is a service fee of $25.00 for all returned checks.

_____ ONLY UNWORN and NON-custom items are returnable within 5 days of receipt. Custom items such as orthotics are non-returnable.

Authorization of Payment

_____ I hereby assign all Medical benefits directly to **East Ocean Podiatry** for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

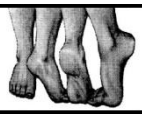
We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor. Suggestions and or grievances can be directed to the doctor via telephone, letter or email.

Patient's Name _____

Signature of Patient/Guardian: _____ Date:_____

Office Witness: _____ Date: _____ _____ Patient initials to indicate copy received

My signature authorizes the assignment of benefits to **East Ocean Podiatry** and will remain on file until further written notification.



EAST OCEAN PODIATRY

PHONE: (954) 481-3525

PATIENT INFORMATION

820 East Hillsboro Blvd. Deerfield Beach, Florida 33441 **Fax: (954) 481-1620**

(***PLEASE*** complete and ***PRINT*** in all applicable spaces)

First Name: _____ MI: _____ Last Name: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Physician: _____ Phone: _____ Last seen: _____

Employer Name/ Address: _____ or Student: Yes / No

Gender: M / F Social Security: _____ Marital Status: _____

I would like to receive quarterly newsletters ☐ E-mail: _____

or scan to join now!

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ If necessary did you bring your referral: Yes / No / NA

Insurance Phone # for providers: _____ Claims Address: _____

Policy/Member: _____ Group / Account Number: _____

Primary Insured's Full Name: _____ Date of Birth: _____ Social Security: _____

Gender: M / F Primary Insured's home address: _____

Employer's Name: _____ Phone: _____

PRIVACY INFORMATION

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Names of family/friends who can pick up your medical records and/medical supplies: _____

Names of family/friends that have parents' authorization to bring in the minor child when guardian is absent:

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the doctors at East Ocean Podiatry.

Representative's Signature: _____ Date: _____

LIKE *"EAST OCEAN PODIATRY"* ON FACEBOOK

MEDICAL HISTORY

PRINT NAME: _____ DATE OF BIRTH: _____

PERSONAL INFORMATION

Reason for visit: _____

Shoe Size _____ Weight _____ Height _____ Do you think you might be pregnant? _____

Smoking: Packs/Day____ Caffeine: Quantity _____ Alcohol: None Rarely Moderately Daily Quit

Recreational Drug Use: None Rarely Moderately Daily Quit

List Athletic Activities: _____

Family History: (i.e.: Diabetes, Heart Disease, and Arthritis) _____

MEDICAL HISTORY: ***Please check ALL that apply.***

- ☐ AIDS/HIV POSITIVE
- ☐ ANEMIA
- ☐ ANGINA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL HEART VALVES
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BACK PROBLEMS
- ☐ CANCER
  LIST TYPE: _____
- ☐ CIRCULATORY PROBLEMS
- ☐ DIABETES
  INSULIN / NON-INSULIN
- ☐ HEART DISEASE
- ☐ FIBROMYALIGIA
- ☐ GOUT
- ☐ HEPATITIS
  ☐ A ☐ B ☐ C
- ☐ HEADACHES/MIGRAINES
- ☐ HYPERTENSION
- ☐ HYPOTENSION
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ OSTEOPOROSIS
- ☐ PHLEBITIS
- ☐ SEIZURE DISORDERS
- ☐ SPORTS RELATED INJURIES
- ☐ STOMACH ULCERS
- ☐ STROKE
- ☐ THYROID DISORDER
- ☐ TUBERCULOSIS
- ☐ OTHER: _____

SURGICAL & HOSPITALIZATION HISTORY ***(Please Include ALL foot related surgeries)***

Surgical History	Date	Surgical History	Date

Medication List: _____

_____

_____

_____

ALLERGIES ***(Check ALL that apply)***

- ☐ SHELLFISH/FOODS
- ☐ LATEX/ADHESIVE TAPE
- ☐ DEMEROL
- ☐ NOVOCAIN
- ☐ SULFA
- ☐ ASPIRIN
- ☐ IODINE/IV CONTRAST
- ☐ PENICILLIN
- ☐ OTHER _____