



Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Northern Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Sex: M F

Social Security #: \_\_\_\_\_ Marital Status: S M D Sep W

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

**Referral:** *how did you find out about us?* \_\_\_\_\_

Race:	Language:	Ethnicity:
White _____	English___ Dutch___	Unknown___
American Indian/Alaska Native _____	Spanish___ Chinese___	Hispanic or Latino___
Asian _____	French___ Japanese___	Non-Hispanic/Latino___
Black/African American _____	Russian___ Italian___	
Native Hawaiian/Pacific Islander _____		

**Family History**

Mother living: \_\_\_ Mother deceased:\_\_\_ Cause of death:\_\_\_\_\_ Age: \_\_\_\_\_

Father living: \_\_\_ Father deceased:\_\_\_ Cause of death:\_\_\_\_\_ Age: \_\_\_\_\_

How many children do you have: \_\_\_Boys \_\_\_Girls?

Any family history of diabetes? \_\_\_No \_\_\_Yes If yes, who? \_\_\_\_\_

Any family history of foot problems? \_\_\_No \_\_\_Yes If yes, who? What type of foot problems?  
\_\_\_\_\_



## Notice of Privacy Act

### Patient Contact

We may contact you to provide appointment reminders, treatment information, billing and payment information, or for patient satisfaction surveys.

### Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Loren Miller all insurance benefits, if any, otherwise **payable to me for services** rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of my benefits. I authorize the use of this signature on all insurance claim submissions. \_\_\_\_\_ (INITIALS)

### Allowed Uses and Disclosures of Your Medical Information:

- Treatment – such as ordering diagnostic test
- Payment – such as submitting information to your insurance company
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.

In addition to the above, your medication information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and if we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances or we created or received the information in treatment.

You have the right to:

- Request a restriction on certain uses and disclosures; however we are not required to agree to any requested restrictions.
- Receive confidential communication from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend copies of your incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice.
- Abiding by the terms of this notice.
- Providing written notice of any change to this notice.

\_\_\_\_\_ (INITIALS)

### Medicare and Insurance Authorization

I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Dr. Loren Miller for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents; the information needed to determine these benefits or the benefits payable for any related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician, agency shown, or supplier agrees to accept the charge determination of the Medicare carrier as based upon the charge determination of the Medicare Carrier. \_\_\_\_\_ (INITIALS)

### Failure to Keep Scheduled Appointments

If you are unable to keep your scheduled appointment, we ask that you please notify our office; at least 24 hours prior to your appointment time. Should you fail to provide proper notice, you will be charged \$50.00 for the time that was allotted to you. By not contacting our office to cancel or reschedule your appointment, those in need of a time slot are unfortunately unable to see us. Thank you for your cooperation. I have read the above policies and I understand and agree to these policies. \_\_\_\_\_ (INITIALS)

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



### Medical History

Please circle "Yes" or "No" if you have had any of the following.

AIDS/HIV	Yes	No	Rheumatoid Arthritis	Yes	No	Varicose Veins	Yes	No
Anemia	Yes	No	Arthritis	Yes	No	Claudication	Yes	No
Bleeding Disorder	Yes	No	Back Problems	Yes	No	(Leg cramps from walking)		
Cancer	Yes	No	Gout	Yes	No	Hepatitis or Jaundice	Yes	No
Hemophilia	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
Swollen Neck Glands	Yes	No	Emphysema	Yes	No	Heart Burn	Yes	No
Angina	Yes	No	Respiratory Disease	Yes	No	Ulcers	Yes	No
Artificial Heart Valve	Yes	No	Shortness of Breath	Yes	No	Weight Loss-unexplained	Yes	No
Chest Pain	Yes	No	Tuberculosis	Yes	No	Numbness or tingling	Yes	No
Circulatory Problem	Yes	No	Chemical Dependency	Yes	No	(in feet or legs)		
Heart Disease	Yes	No	Psychiatric Care	Yes	No	Seizures	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No	Fainting	Yes	No
Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No	Neurological Problems	Yes	No
Rheumatic Fever	Yes	No	Eye Problems	Yes	No	Venereal Disease	Yes	No
Stroke	Yes	No	Sinus Problems	Yes	No	Kidney Problems	Yes	No
Swelling Ankles/Feet	Yes	No	Headaches	Yes	No	Rash	Yes	No
Heart Attack	Yes	No	Phlebitis	Yes	No			

### Allergies

- Adhesive tape
- Anticoagulant Therapy
- Aspirin
- Codeine
- Cortisone
- Demerol
- Iodine
- Latex
- Local Anesthesia
- Novocain
- Penicillin
- Seafood
- Sulfa

OTHER:

\_\_\_\_\_

\_\_\_\_\_

### Podiatric History

Describe the chief complaint for which you came to be treated (include foot, ankle, knee, thigh, and hip complaints). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has chief complaint been present?    \_\_\_ wk    \_\_\_ mo    \_\_\_ yr

On a scale of 1-10, how bad is the pain?

1    2    3    4    5    6    7    8    9    10

**Foot Disorder** Please indicate which foot problems you now have or had in the past.

Ankle Pain	yes	no	Heel Pain	yes	no
Athlete's Foot	yes	no	Ingrown Toenails	yes	no
Bunions	yes	no	Plantar Warts	yes	no
Corns/Calluses	yes	no	Infection	yes	no
Deformed Toes	yes	no	Ulcer/Wound	yes	no
Fungus Nails	yes	no	Tired Feet	yes	no



**Medical History (cont.)**

Cigarette/Tobacco use?      yes      no

How much alcohol do you consume?

(Circle one) Current or Former user?

\_\_\_ daily      \_\_\_ weekly      \_\_\_ monthly

Time smoked: \_\_\_\_\_

Surgeries I've had:

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Medications:

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Preferred Pharmacy Name: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

(or) Pharmacy Location: \_\_\_\_\_

**CONSENT**

I certify that the above information is correct to the best of my knowledge. I give permission to Dr. Miller to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Review of Systems

For new patients, established patients who may be having a new problem, or our patients who haven't been seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please circle "No." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE YES**. If you have any questions about this, please ask one of the technicians or the doctor.

### Constitutional

Weight loss	Yes	No
Weight gain	Yes	No
Fever	Yes	No
Fatigue	Yes	No

### Dermatologic

Skin infections	Yes	No
Psoriasis (skin disease)	Yes	No
Spider veins	Yes	No
Blisters	Yes	No
Moccasin rash (Athlete's Foot)	Yes	No
Macerated webspaces	Yes	No
Rash	Yes	No
Bleeding	Yes	No
Bruising	Yes	No
Itching	Yes	No
Hypertrophy toenails (thick nails)	Yes	No
Foot ulcers	Yes	No

### Neurologic

Paralysis (loss of ability to move)	Yes	No
Stroke	Yes	No
Tics	Yes	No
Tremors	Yes	No
Foot numbness	Yes	No
Seizures	Yes	No
Tingling feet and/or hands	Yes	No

### Musculoskeletal

Joint pain	Yes	No
Joint swelling	Yes	No
Muscle pain	Yes	No
Pain after resting	Yes	No
Joint disability	Yes	No
Weakness	Yes	No
Back pain	Yes	No

# OUR FINANCIAL POLICY



Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to sign prior to any treatment.

All patients must complete our information packet and produce all insurance cards and id prior to seeing the doctor.

**CUSTOM MADE PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON REFUNDABLE.**

**24 Hours notice is required in the event you cannot keep your appointment. If notice is not given in a timely manner there is a mandatory \$50.00 no show fee.**

**ALL returned checks have a \$25.00 processing fee applied to the account.**

**Non insurance patients (self pay) full payment is due at time of service.** We accept cash, check, credit card, etc.

## **Regarding insurance**

We may accept assignment of insurance benefits. **ALL co pays, coinsurance and deductibles are due at the time of service.** In the event that your insurance is not in network you will be considered self pay. **The balance is your responsibility whether your insurance company pays or not.** Your insurance policy is a contract between you and your insurance company. We are not a third party to that contract. Please be aware that some, perhaps all, of the services provided may be non covered services and not considered reasonable under your insurance program.

## **Usual and customary rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

## **Adult patients**

Adult patients are responsible for their portion of payment at the time of service depending of self pay or insurance coverage.

## **Minor patients**

The accompanying parent or guardian is responsible for full payment. For non accompanying minors, non emergency treatment will be denied.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this financial policy:

Signed Name \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_



## CONSENT FOR BIOLOGICAL TRANSFER

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 Advanced Foot and Ankle Surgery 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 Advanced foot and Ankle Surgery 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.**

Signature of patient \_\_\_\_\_

Printed name of patient \_\_\_\_\_

Date \_\_\_\_\_