**PATIENT INFORMATION**

First: _____ M.I._____ Last: _____

Preferred Name: _____ Sex: ☐ M ☐ F DOB: _____

Mobile Phone: _____ E-mail: _____

Home Phone: _____ Work Phone: _____

Preferred method of communication: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____

Phone # _____ Alternative# _____

Patient relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor Name: _____

Guarantor Address: _____

Guarantor City: _____ State: _____ Zip Code: _____

Guarantor DOB: _____ ☐ M ☐ F Social Security #: _____

Guarantor Phone: _____ Secondary Phone: _____

Patient's Ethnicity: _____ Language: _____ Patient's Race: _____

Primary Doctor: _____ Last Visit: Month _____ Year_____

How did you hear about us? ☐ Google ☐ Yelp ☐ Website ☐ Insurance

☐ Referred by: _____

Pharmacy: _____ Phone Number: _____

**Prescription History**

In order to have the most current prescription information, we need to request the information electronically. Do we have permission to do so? ☐ Yes ☐ No

Signature: _____ Date: _____

Primary Doctor: _____ Phone No: _____ Date of last exam: _____

Describe the condition that brought you to this office: _____

If auto accident, date of accident _____ Previous care for this condition? ☐ Yes ☐ No

Dr. _____ Date: _____

**HEIGHT: _____ WEIGHT: _____ HAVE YOU RECEIVED THE FLU SHOT THIS YEAR? ☐ YES ☐ NO**

**MEDICAL: (Please check any of the following if it pertains to you)**

| | | | |
|---|---|---|---|
| ___ Diabetes | ___ Phlebitis | ___ Scar Former | ___ Asthma |
| ___ Angina/Chest Pain | ___ Bleeding Disorders | ___ Angioplasty | ___ Depression |
| ___ Kidney Disorder | ___ Seizures | ___ Ulcers | ___ Hypercholesterol |
| ___ Human Immunodeficiency Virus (HIV) | ___ Circulation Disorder | ___ ADHD | ___ Hyperthyrodism |
| | ___ Stroke/TIA's | ___ Hypertension | ___ Hypothyrodism |
| ___ Heart Attack | ___ Bipolar | ___ Hepatitis | |

**ALLERGIES:**

___ None ___ Penicillin ___ Aspirin ___ Codeine ___ Novocain ___ Iodine ___ Latex

Other: _____

**MEDICATIONS: (Please include Aspirin, Tylenol, Vitamins and Birth Control Pills)** ___ See attached list

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7_____ 8 _____

**PREVIOUS SURGERIES AND HOSPITALIZATIONS:**

1 _____ 2 _____ 3 _____ 4 _____

Please check all the apply

**FAMILY HISTORY**

☐**MATERNAL** ☐Diabetes ☐High Blood Pressure ☐Bleeding Tendencies ☐Other _____

☐**PATERNAL** ☐Diabetes ☐High Blood Pressure ☐Bleeding Tendencies ☐Other _____

**SOCIAL HISTORY:**

| | | | | |
|---|---|---|---|---|
| Alcohol Intake | ☐None | ☐Occasional | ☐Moderate | ☐Heavy |
| Caffeine Intake | ☐None | ☐Occasional | ☐Moderate | ☐Heavy |
| Illicit Drugs | ☐None | ☐Occasional | ☐Moderate | ☐Heavy |
| Exercise Level | ☐None | ☐Occasional | ☐Moderate | ☐Heavy |
| Smoking Status | ☐Never | ☐Former | ☐Current | |
| General Stress Level | ☐Low | ☐Medium | ☐High | |

**PODIATRIC HISTORY:**

| | |
|---|---|
| ___ Flat Feet | ___ Pain or fatigue in feet & legs with activity |
| ___ Heel or arch pain (Child or Adult) | ___ Numbness and tingling in feet and toes |
| ___ Pain in feet getting out of bed | ___ Bunions (prominent foot bones) |
| ___ Crooked toes (hammertoes) | ___ Ankle swelling & stiffness |
| ___ Ankle instability (easy twisting injuries) | ___ Leg pain (shin splints) |
| ___ Growing pains | ___ Difficulty walking/running |
| ___ Poor coordination with sports | ___ In-toe or out-toe gait |
| ___ Abnormal foot posture (clubfoot, metadductus) | ___ Achilles' tendon pain |

Other problems with your feet/legs: _____

**South Florida Lower Extremity Center**
**Dr. Nooshin Zolfaghari D.P.M and Dr. Igor Zilberman D.P.M.**
**Foot and Ankle Surgeon**
**2699 Stirling Road Suite A-301 / 302**
**Office (954) 278-3890 / Fax (954) 251-1470**

## ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: I _____,
Do hereby IRREVOCABLY ASSIGN to the above-named medical provider, any right or benefits under my policy of insurance with _____, for any service and/or charges provided by the above medical provider. Pursuant to this ASSIGNMENT OF BENEFITS, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. As part of this ASSIGMENT OF BENEFITS, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **South Florida Lower Extremity Center** is to be set aside and not disbursed until the dispute is resolved.

IN WITNESS WHEREOFF the undersigned has hereunto set his/her hand, this ___ day of _____, 20___.

_____ _____

Patient's Signature Patient's Name (please print)

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## ACKNOWLEDGEMENT OF RECEIPTS OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

**(Read before singing the Acknowledgement and Consent)**

This Acknowledgement of notice and consent authorizes **South Florida Lower Extremity Center** to use health information about you for treatment, payment, and health care operations purposes.

**NOTICE OF PRIVACY PRACTICES: South Florida Lower Extremity Center** has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

**AMENDMENTS:** We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

### How to contact our Privacy Officer

**Mail: 2699 Stirling Road Suite A301/302 Hollywood, FL 33012**
**Tel: (954) 278-3890 /Fax: (954) 251-1470**

### Acknowledgement and Consent

I have received the Notice of Privacy Practices for **South Florida Lower Extremity Center** is authorized to use health information about (please print patient's name)
_____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____ _____
Signature of Patient Date Account #

Personal representative information (if applicable):

_____ _____
Name of Personal Representative Relationship to Patient

**IDENTITY OF RECEPIENTS:** Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message: ☐YES ☐NO

___ Daytime phone / Ph# _____
___ On my home answering machine / Ph# _____
___ On my voicemail / Ph# _____
___ With my designated and authorized person(s) named below:

_____

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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.

Throughout your course of care at **South Florida Lower Extremity Center**, 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 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 transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case during a routine or surgical procedure, that biological specimens such your blood, urine, hair, or bodily fluids may be deposited on medical instruments, bedding, clothing or other objects. These objects may 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 **South Florida Lower Extremity Center** to a third party as described above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Patient Printed Name

_____

Patient Signature/Parent or Legal Guardian Signature for Minor Patient

_____

Date

# MEDIA RELEASE FORM

I, _____, grant permission to South Florida Lower Extremity Center to use my image (photographs and/or video) for use in media publications including:

☐ Facebook ☐Instagram ☐ Brochures ☐ Email Blasts (Mailchimp)

☐ Other: _____

I hereby waive any rights to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, weather that use is known to me or unknown.

Please **initial** the paragraph below which is applicable to your present situation:

_____ I am 21 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Patient Name: _____ Date: _____

Name: (Please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 21 years old of age)

# OUR CANCELLATION / NO-SHOW POLICY

DUE TO THE INCREASING NUMBER OF NO-SHOW AND SAME DAY CANCELLATIONS OF APPOINTMENTS, WE ARE INSTITTUING A NEW POLICY, EFFECTIVE IMMEDIATELY.

**THE POLICY IS AS FOLLOWS:**

1. Cancelled appointments within 24 hours of appointment time - **$25.00 fee**
2. No show for appointment time - **$50.00 fee**
3. Surgery cancellation within five days of schedule surgery time – **$750.00 fee**
4. Any forms or letters will charge accordingly.

# OUR STAFF APPRECIATES YOUR UNDERSTANDING

## THANK YOU,

I have read and agree to the above policy.

Patient's Signature Patient Print Date

Your payment information

*We Accept*


Card Details

Card Number

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |

Expiration Date

| |
|---|
| / |

CCV

| | | |
|---|---|---|
| | | |