

Coastal Foot & Ankle Wellness Center * New Patient Info & Chart Update

Please Complete ALL Sections - *Thank You* - (Please Print)

Date: _____ Sex: M ___ F ___ Birthdate: _____ Email: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Ph#: (____) _____ Secondary #: _____ Are You Active Military? _____

Employer Name: _____ Employer Ph#: _____

Occupation: _____ Full or Part-Time? _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed ___ Other

Primary Language Spoken: _____ When is the last time you saw a podiatrist? _____

Race: ___ White/Caucasian ___ Black/African-American ___ Other

Ethnicity: ___ Spanish ___ Asian ___ Other

Name and DOB of Insurance Policy Holder if Other than Patient: _____ / _____

How Did You Hear About Our Office? _____

What Problem Brings You to the Office Today? _____

Is Your Visit ACCIDENT or WORKCOMP related? (Circle One): YES / NO

**** Please Note:** If this is in any way Accident (either auto or anywhere outside of your own home) or WorkComp related, you will need to contact the Case Adjustor, your Auto Insurance or Human Resources to be referred to a physician in-network with their services. Even if you have yet to file an accident claim, we will not be able to bill your usual health insurance policy. Please advise staff right away if accident.

What is the Name of Your Primary Care Physician? _____

Do you have an Endocrinologist? If yes, what is his/her name? _____
(Doctor who treats your diabetes)

Whom May We Contact In Case of Emergency?

Name: _____ Ph#: _____ Relationship: _____

Parent/Guardian Name (for patients under the age of 18): _____

(*Please Note: If patient is a minor, we need the guardian's employment information completed above)

Parent/Guardian DOB: _____

Financial Policy for Coastal Foot & Ankle Wellness Center

All professional services rendered are charged to the patient, who is responsible for all fees, regardless of insurance coverage. Please read the following policies and ask about any questions that you may have prior to signing.

1. I hereby authorize Coastal Foot & Ankle and Wellness Center to furnish information concerning my illness and treatments to my insurance carrier(s) on my behalf.
2. I authorize the use of this form, or a copy of it, to be used on all my insurance submissions, and I authorize payment to be sent directly to Coastal Foot & Ankle.
3. If, for any reason, my insurance company denies payment-- due to deductibles or non-covered services-- I will be responsible for the amount charged by the physician for his/her services at the time of the visit.
4. If my account should fall delinquent, I understand that I will be responsible for payment of all collection costs and all legal fees.

Signature: _____ Date: _____

**** COPAYMENTS ****

If your insurance has an assigned COPAY, that copay must be paid at the time of service for each applicable office visit. Please Note: We are considered a Specialist Office.

Types of Payments Accepted

* CASH * CREDIT/Debit CARD: Visa/Mastercard * CHECK * MONEY ORDER

IMPORTANT NOTICE:

To comply with the Federal Anti -ID -Theft Laws, we are ***required*** to scan and keep a photocopy of your driver's license or alternate government-issued photo ID as well as a copy of your insurance card(s).

New patients who present without a valid photo ID cannot be seen until such ID can be presented.

Please Note: We encourage patients to sign up for our secure Coastal Patient Portal for access to all patient notes and for additional communication with the office. You must provide us with an active EMAIL account in order to sign up for the portal. -- All patients have the right to a summary printout of their visit. If you do not have email, or elect not to sign up for the patient portal and would like a copy of your visit summary before you leave, please inform the front desk and one will be printed for you if the physician has finished the note before you are ready to leave. Otherwise, you may request a copy of any of your records at any time, but please allow staff up to four (4) business days to provide you with this requested documentation. Please Note: Lab Findings and Imaging Reports cannot be released to the patient by our staff until the doctor has reviewed the results with the patient or otherwise gives express consent to release said reports.

Coastal Foot & Ankle Wellness Center

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- * Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- * Obtain payment from third party payers.
- * Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received and/or read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. A notice of these practices is on display in the waiting room of each office, in full view of the public. I understand that Coastal Foot & Ankle Wellness Center has the right to change it's Notice of Privacy Practices from time to time and that I may contact Coastal at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that that Coastal Foot & Ankle is not required to agree to my requested restrictions, but if agreement is made, they are bound to abide by such restrictions.

Patient Name: (please print) _____

Parent/Guardian (*if patient is a minor*) _____

I hereby give consent and authorize Coastal Foot & Ankle Wellness Center to allow the person(s) listed below to have access to my account information, including communication with the office staff/doctors on my behalf.

_____/ Relationship: _____

_____/ Relationship: _____

_____/ Relationship: _____

I choose **NOT** to authorize any individual (including family) to have access to my account. (Please check)

Patient Signature: _____ / **Date:** _____

Coastal Foot & Ankle Wellness Center
PAST and PRESENT Patient Medical History ---- PLEASE PRINT

PATIENT NAME: _____ / **DOB:** _____

Are You Diabetic? YES / NO **If yes, are you insulin dependent?** YES / NO

Medication Allergies: _____

____ No Known Drug Allergies ____ Allergic to Latex ____ Allergic to Tape

Food Allergies: _____

CURRENT MEDICATIONS

**** Please sign your name on the line below if you consent to our physicians obtaining your prescription information from the pharmacy database. Information received is for patient care only and the information retrieved will become a part of your HIPAA protected chart.**

Patient Signature: _____

Check here ____ if you do NOT authorize us to obtain a list of medications from the pharmacy database.
(Please Note: In order to protect your health from potential contraindicated medication complications, our physicians will not be able to write any prescription for any patient who has not given consent to obtain a full Rx medication list).

Medication _____	Frequency _____	Mg _____
Medication _____	Frequency _____	Mg _____
Medication _____	Frequency _____	Mg _____

What is Your Preferred Pharmacy? _____ **Street or Location:** _____

SMOKING

Are you **currently** a smoker? YES / NO If yes, how many packs per day? _____ # of Years? _____

How soon after you wake up do you smoke? _____ Are you interested in quitting? YES / NO

If you are NOT currently a smoker, did you smoke in the past? YES / NO If yes, # Yrs you smoked? _____

How many packs per day did you smoke? _____ How long ago did you quit? _____

DRUG USE: Do you take illegal drugs or illegal Rx medications? YES / NO If yes, what drug? _____

ALCOHOL: Do you drink alcohol? YES / NO If yes, how many drinks on a typical day? _____

How often did you have a drink with alcohol in it over the last year? _____

Are you interested in quitting? YES / NO

HEIGHT: _____ (feet) _____ (inches) **CURRENT WEIGHT:** _____ lbs

DNA: Per the recent State of Florida's DNA Privacy Act, we are required to inform you that we do not collect, retain or distribute your DNA for the purpose of genetic testing. Any DNA (hair, blood, bodily fluid, toenails, skin, etc) that may potentially be obtained as part of the natural course of care (ie: in-office procedure, cutting nails) will be properly disposed of (via biohazard containment/destruction, if necessary) unless that DNA (ie: skin, blood, toenail, etc) needs to be submitted to a laboratory for further medical testing that is pertinent to your care.

PATIENT SIGNATURE acknowledging DNA Privacy Act and giving permission to have DNA obtained during course of care to go to biohazard bin unless it is needed for lab: _____

Coastal Foot & Ankle Wellness Center

PAST and PRESENT Patient Medical History - Continued

PATIENT NAME: _____ / DOB: _____

Do You Have METAL in Your Body? YES / NO If yes, where? _____

FAMILY HISTORY (circle all that apply)

Mother: Heart Attack Stroke Diabetes
Father: Heart Attack Stroke Diabetes
Grandparent: Heart Attack Stroke Diabetes

PAST – or -- PRESENT Illnesses (Please circle all that apply)

Asthma Emphysema Cancer (Type) : _____ Liver Disease
Hypothyroid Hyperthyroid GERD Sleep Apnea High Blood Pressure DVT
Peripheral Vascular Disease Coronary Artery Disease Arrhythmias AFIB
Osteoporosis Osteoarthritis Heart Attack (What Age?) _____ Stroke (What Age?) _____
Macular Degeneration Blindness Hearing Loss Deafness Hepatitis HIV/Aids
Polio Tuberculosis Anxiety Depression Nervousness Bipolar Disorder OCD
ADHD Schizophrenia Murmur Anemia Clotting Problem Mitral Valve Prolapse
Circulator Problems Abdominal/Aortic Aneurysm High Cholesterol Low Cholesterol
High Triglycerides Low Triglycerides COPD Eczema Psoriasis Neuropathy
Epilepsy Alzheimers Parkinsons Aneurysm Multiple Sclerosis Fibromyalgia
Rheumatoid Arthritis Other: _____

PAST SURGERIES / PROCEDURES: (Please circle any that apply)

Appendectomy Back Heart Bypass Gallbladder Hernia Hip Hysterectomy
Foot Ankle Intestinal Leg Stents Joint Replacement (What joint? _____)

Other: _____

Please list anything regarding your foot / leg health (past or present) that you feel would be beneficial for the doctors to know:

