



PATIENT INFORMATION

First: _____ M.I. _____ Last: _____

Preferred Name: _____ Sex: M F DOB: _____

Social Security #: _____

Mobile Phone: _____ E-mail: _____

Home Phone: _____ Work Phone: _____

Preferred method of communication: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Insurance Name: _____

Policy # _____ Group # _____

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? _____

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: _____ Date: _____

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

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Scar Former | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Human Immunodeficiency Virus (HIV) | <input type="checkbox"/> Circulation Disorder | <input type="checkbox"/> ADHD | |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke/TIA's | <input type="checkbox"/> High Blood Pressure | |
| | <input type="checkbox"/> Bipolar | <input type="checkbox"/> 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 _____

PREVIOUS SURGERIES AND HOSPITALIZATIONS:

1 _____ 2 _____ 3 _____ 4 _____

Please check all the apply

FAMILY HISTORY: Diabetes High Blood Pressure Bleeding Tendencies Other

SOCIAL HISTORY:

- | | | | | |
|-----------------------------|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------|
| Alcohol Intake | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Caffeine Intake | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Illicit Drugs | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Exercise Level | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Smoking Status | <input type="checkbox"/> Never | <input type="checkbox"/> Former | <input type="checkbox"/> Current | |
| General Stress Level | <input type="checkbox"/> Low | <input type="checkbox"/> Medium | <input type="checkbox"/> High | |
| Live alone or with others? | | <input type="checkbox"/> Alone | <input type="checkbox"/> Others | |
| Single or multi-level home? | | <input type="checkbox"/> Single | <input type="checkbox"/> Multi | |

PODIATRIC HISTORY:

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

Other problems with your feet/legs: _____

VIP Foot and Ankle Center
Nooshin Zolfaghari D.P.M., Foot and Ankle Surgeon
17751 SW 2nd Street
Pembroke Pines, FL 33029
Office (954) 251-1687 / Fax (954) 613-5193

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 ASSIGNMENT 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 **VIP Foot and Ankle 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 signing the Acknowledgement and Consent)

This Acknowledgement of notice and consent authorizes **VIP Foot and Ankle Center** to use health information about you for treatment, payment, and health care operations purposes.

NOTICE OF PRIVACY PRACTICES: **VIP Foot and Ankle 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 conduct our Privacy Officer

Mail: 17751 SW 2nd Street, Pembroke Pines, FL 33029 Tel: (954) 251-1687 / Fax: (954) 613-5193

Acknowledgement and Consent

I have received the Notice of Privacy Practices for **VIP Foot and Ankle 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 RECIPIENTS: 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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Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. **As of September 1st, 2017, there will be a fee of \$25 assessed if we do not receive a 24 hours call prior to your appointment time.**

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Thank You,

The Staff of VIP Foot and Ankle Center

I acknowledge and accept the cancellation policy.

Please Print Name

Date

Patient's Signature