Denis Foot and Ankle Specialists, Inc.

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: (circle one) Single / Mar / Div / Sep / Widow

Is this your legal Name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth Date: ___/___/___	Age:	Sex: ☐ M ☐ F

Street Address:	Social Security No.:	Home Phone No.: ( )

Apt No.:	City:	State:	Zip Code:	Cell Phone No.: ( )

Occupation:	Employer:	Employer Phone No.: ( )

Referred to clinic by (please check on box):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other (specify)

Other family members seen here:

EMAIL: PHARMACY NAME/ PHONE:

LANGUAGE: ENGLISH ☐ SPANISH ☐ OTHER ____________________

RACE: AMERICAN INDIAN / ALASKA NATIVE☐ ASIAN☐ BLACK/ AFRICAN AMERICAN ☐ MORE THAN ONE RACE ☐ NATIVE/HAWAIIAN ☐ PACIFIC ISLANDER ☐ UNREPORTED/REFUSED TO REPORT☐ WHITE ☐

ETHINICTY: ☐ HISPANIC/LATINO ☐ NON HISPANIC/LATINO ☐ UNREPORTED/ REFUSED NOT TO REPORT RACE AND IDENTITY

INSURANCE INFORMATION

(Please give your insurance card to the Receptionist.)

Person responsible for bill:	Birth Date: ___/___/___	Address (if different):	Home Phone No.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer Address:	Employee Phone No.:

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance:	Please indicate secondary insurance:

Subscriber's Name:	Subscriber's SSN:	Birth Date ___/___/___	Group No.:	Policy No.:	Co-Payment: $
Subscriber's Name:	Subscriber's SSN:	Birth Date ___/___/___	Group No.:	Policy No.:	CO-PAYMENT $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Denis Foot and Ankle Specialists, INC or insurance company to release any information required to process my claims.

__________________________________ ____________________

Patient/Guardian Signature *Date*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

Denis Foot and Ankle Specialists, INC
Podiatry Medicine and Surgery
Emma Denis, D.P.M.
Phone: (904) 771-5339

PLEASE ANSWER THE FOLLOWING QUESTIONS.

Name____________________________________ **Date of Birth**____________________________

PRIMARY MEDICAL DOCTOR:____

LAST SEEN AND WHY? ____

ARE YOU PREGNANT? **Y / N** DO YOU SMOKE? **Y / N** DO YOU DRINK ALCOHOL? **Y / N**

ARE YOU TAKING ANY MEDICATIONS? **Y / N** PLEASE LIST:____________________________

____

DO YOU HAVE ANY ALLERGIES TO MEDICINES? **Y / N** PLEASE LIST: ____________________

____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK.

HEART DISEASE	____	HIGH BLOOD PRESSURE	____
DIABETES	____	CANCER	____
KIDNEY DISEASE	____	LIVER DISEASE	____
HIV INFECTION	____	STOMACH ULCERS	____
CIRCULATION PROBLEMS	____	PROBLEMS HEALING	____

WHAT IS YOUR FOOT PROBLEM? ____

____

WHEN DID THIS PROBLEM START? ____

____

IS THIS PROBLEM RELATED TO AN ACCIDENT? **Y / N** DATE OF INJURY: ________________

HAVE YOU RECEIVED ANY TREATMENT FOR THIS PROBLEM? **Y / N** IF YES, EXPLAIN:

____

____

____

Denis Foot and Ankle Specialists, INC
Podiatry Medicine and Surgery

Authorization for Release of Medical Information

Patient's Name:____

Birth Date:______________ Social Security #:______________________________

Address:__________________________________Telephone #:__________________

I hereby authorize______________________________________ to release healthcare information of the patient named above to:

Dr. Denis Foot and Ankle Specialists
7855 Argyle Forest Blvd. Suite #901
Jacksonville, FL 32244
Phone #: (904) 771-5339 Fax #: (904) 771-5340

This request and authorization applies to:

__ Healthcare information regarding to the following treatment, condition, or dates:
____
__ All healthcare information
__Other:____

Dates of Service Needed:
From_____________________ To:_______________________
___ All dates of service

I hereby authorize **Denis Foot and Ankle Specialists, Inc.** to obtain my medical records on my behalf. Please release all my medical records including: Progress Notes, History and Physical, Medications History, and any Diagnostic Tests rendered by you or under your supervision.

This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations.

I understand Florida Statue makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information.

____
Signature of Patient

____
Signature of Legal Representative or Parent/Guardian

____
Patient's Name (Print)

____
Relationship to Patient

____
Date Signed