PRECISION
FOOT AND ANKLE, P.A.
P: (727) 399-7167
www.precisionfootandankleFL.com

Pinellas Park Location
7800 66th Street N Ste 207
Pinellas Park, FL 33781

New Patient Paperwork

Today's Date: _____/_____/_____

Patient Name:	***Last*** ***First*** ***MI***	***Date of Birth***	**Sex (Circle):** **M F**
Home Address:	***City/State***	***Zip***	
Home Phone #	***Work Phone #***	***Cell Phone #***	
Email Address (Mandatory)		***Primary Language***	
Primary Care Doctor:		**Phone:**	
Date of Last Primary Care Appointment:			
Preferred Pharmacy		***Pharmacy Phone Number***	

How did you hear about us? ☐ Insurance Company Website ☐ Referral ☐ Google ☐ ZocDoc ☐ Friend ☐ Online ad ☐ Medical Lecture ☐ Postcard ☐ Other: _____

Current Problem

What is the reason for your visit today?

How long ago did this problem start? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Did the pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe the pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate the pain on a scale from 0 to 10? (Please Circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain possible)

Since the pain began, has it: ☐ stayed the same ☐ become worse ☐ improved

What makes your pain or problem worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress shoes ☐ High Heels ☐ Flat Shoes ☐ Closed Toe Shoes ☐ Running ☐ Other:_____

What treatments have you had for this problem?

Was this problem caused by an injury? ☐ YES (describe) _____ ☐ NO

If so, was this injury work-related? ☐ YES ☐ NO

Medical History

List ALL of your medical problems:

Surgical History – Please List All Prior Surgeries and the Date of The Surgeries	
1.	4.
2.	5.
3.	6.
Family History: What medical problems run in your family?	
Social History	
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed	
Alcohol Use: ☐ Never ☐ No Longer Use ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily	
Tobacco Use: ☐ Never ☐ Quit – How long ago? _____ ☐ Smoke _____ Packs/Day for _____ Years	
Recreational Drugs:	
Employer:	**Occupation:**

Allergies: Please List All Of Your Allergies Below:	
Medication Allergies:	**Other Allergies:**

Medications – Please List All Medications You Are Currently Taking (Including prescriptions, over-the-counter and herbal supplements)

Medication	*Dose*	*How Often Do You Take?*	*Medication*	*Dose*	*How Often Do You Take?*

Review of Systems	
Do you have any problems with the following?	
❑ Unexplained changes in weight	❑ Bleeding problems
❑ Fevers or chills	❑ Kidney problems
❑ Vision problems	❑ Liver problems
❑ Hearing problems	❑ Skin problems
❑ Lung problems	❑ Nerve problems
❑ Stomach problems	❑ Back problems

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

Patient Name (Print here)	***Signature***	***Date***

Physician Signature	***Date***

*Physician has reviewed the above information as part of the evaluation and management services and as part of the subjective findings

Patient First Name Last Name	*Date of Birth* Month / Day / Year
Street Address	Legal Guardian Name if different from patient
City / *State* / *Zip*	Phone Number

AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION

I, the patient, legal guardian or health care surrogate, hereby authorize Precision Foot and Ankle, P.A. doctors and staff to examine and treat the aforementioned, if necessary. I understand that this consent may be withdrawn at any time and withdrawal of consent must be in writing to the Precision Foot and Ankle, P.A. doctors and staff. I understand that photographs may be taken by Precision Foot and Ankle PA doctors and staff for documentation purposes to be included as part of the medical record.

The patient, legal guardian or health care surrogate authorizes Precision Foot and Ankle PA doctors and staff to disclose appropriate and necessary clinical information to other facility staff for the purpose of treatment. Clinical information can be released to family members listed below for purposes of treatment:

1.
2.
3.

ASSIGNMENT OF BENEFITS

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible. You agree to allow Precision Foot and Ankle, P.A. to bill your insurance directly and receive payments for services rendered. You may be responsible for any non-covered services and your portion of payments that are patient responsibility.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please feel free to contact us.

If you believe that your privacy rights have been violated, you may file a complaint with our HIPPA Privacy Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Requested medical records will be provided *within 30 days of the date of request.*

AWKNOWLEGEMENT OF AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND NOTICE OF PRIVACY PRACTICES

I, the patient or legal representative have reviewed the above information and agree to allow Precision Foot and Ankle, P.A. doctors and staff to proceed with treatment of the above-mentioned payment and agree to the above terms of service.

Signature of Patient or Legal Representative	***Date***