PATIENT INFORMATION FORM

DATE / /

Welcome to Broward Podiatry Associates. Please take a few moments to carefully fill out this form. This information will better help us serve you.

1. Name _____ Address _____

   City _____ State _____ Zip _____

   Telephone # Home _____ Office _____ Cell Phone _____

2. Date Of Birth: Month _____ Day _____ Year _____ Age _____ Sex M ____ F ____

3. Social Security # _____ Height _____ Weight _____ Shoe Size _____

4. Place Of Employment _____ Occupation _____

5. Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ # of Children _____

6. Spouse's Name: _____ Employer _____

7. Person Responsible For Paying Your Medical Bills? Self _____ Relationship _____

   Name _____ Address _____

8. Primary Insurance: _____ Policy # _____

   Second Insurance: _____ Policy # _____

   Medicare # _____ Medicaid # _____

9. Name Of Your Family Physician _____ Last Seen _____

10. Have You Seen A Podiatrist Before? _____ If So, What For? _____

11. What Foot Problem Has Caused You To Seek Treatment At This Office? Describe Below.

    _____

    _____

12. When Did This Problem Begin? Please Give A Brief History About How The Condition Has Progressed.

    _____

    _____

13. How Much Walking Do You Do? _____ Jogging? _____

14. How Did You First Hear About This Office? _____

15. Are You Here For A Consultation Or Treatment? _____

PLEASE FILL IN THE MEDICAL HISTORY ON THE REVERSE SIDE (Turn Over)

MEDICAL HISTORY

	Check One Yes	No
1. Are You In Good Health? _____	☐	☐
2. Do You Smoke? If So, How Much? _____ # Years _____	☐	☐
3. Do You Drink Alcohol? If So, How Much? _____	☐	☐
4. Have You Had Rheumatic Or Scarlet Fever, Tuberculosis, Diptheria? If So, Circle.	☐	☐
5. Any Family History Of Diabetes, Heart, Lung, Or Circulatory Disease, Cancer, Epilepsy, Tuberculosis, Or Asthma? If So, Circle.	☐	☐
6. Do You Take Medications? List All. _____	☐	☐
_____		
7. Any Side Effects From Novacaine, Penicillin, Codeine, Sulfa Drugs, Aspirin, Other Antibiotics, Adhesive Tape, Or Topical Iodine? If So, Circle.	☐	☐
8. Any Other Allergy Or Sensitivity To Medications Or Substances? List. _____	☐	☐
_____		
9. Any History Of Having Diabetes, Stroke, Poor Circulation, Heart, Liver, Lung, Kidney, Or Gastrointestinal Disease, Gout, Arthritis, Cancer, Phlebitis, Or Immunosupression? If So, Circle.	☐	☐
10. Any Other Medical Illnesses Or Conditions? If So, List Below. _____	☐	☐
_____		
11. Any Serious Illnesses, Operations, Or Hospitalizations In The Past 5 Years? List. ___	☐	☐
_____		
12. Are You Subject To Prolonged Bleeding Or Slow Healing?	☐	☐

13. I HEREBY AUTHORIZE AND GIVE MY PERMISSION TO BROWARD PODIATRY ASSOCIATES, TO ADMINISTER TREATMENT AND PERFORM SUCH MINOR PROCEDURES AS DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION.

SIGNATURE _____ DATE _____

14. I HEREBY AUTHORIZE ANY INSURANCE COMPANY AND/OR MEDICARE TO PAY THE PROCEEDS OF ANY BENEFITS DUE TO ME DIRECTLY TO: BROWARD PODIATRY ASSOCIATES, OR THEIR AUTHORIZED AGENT. MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS MAY BE RELEASED.

SIGNATURE _____ DATE _____
(Used For Signature On File)

THANK YOU FOR FILLING OUT THIS FORM. IT IS OF GREAT VALUE TO US TO MAINTAIN CLEAR AND ACCURATE RECORDS ON YOUR BEHALF. BROWARD PODIATRY ASSOCIATES ARE DEDICATED TO PROVIDING A FULL AND COMPLETE MEASURE OF PROFESSIONAL SERVICE AND ATTENTION TO PATIENTS IN OUR PRACTICE

CONTACT INFORMATION UPDATE

NAME_____ DATE_____

Next year we will be reminding you of your appointment by Email, phone and/or text message which will also confirm your appointment. Please confirm your contact information.

Email address (PLEASE PRINT CLEARLY)	**Cell Phone #**	**Landline #**

I acknowledge that the above information is correct and can be used to notify me and leave messages from Broward Podiatry Associates, PA and Dr. George Jacobson. This information will not be shared with third parties.

Signature	**Date**

FAIRNESS POLICY

TRY TO BE ON TIME. I DO. WE STRIVE TO RUN ON TIME AND OCCASIONALLY RUN LATE.

If you are late, everyone after your appointment time will be delayed. We will take the next scheduled appointment and try to work you into the schedule. If you are very late you may need to reschedule. (OUR PATIENTS THANK YOU FOR YOUR TIMELINESS)

We do not want to be hurried while treating you.
If you are constantly late or miss appointments we will ask you to see another provider.

I understand this policy and agree to it.

_____ _____

Signature Date

_____

Print your name

Broward Podiatry Associates, P.A.
George Jacobson, D.P.M.
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have reviewed/received a copy of
Patient Name

Broward Podiatry Associates, P.A. 's Notice of Privacy Practices.
Practice Name

_____ _____
Signature of Patient/Guardian Date

OFFICE USE ONLY

BROWARD PODIATRY ASSOCIATES, PA
GEORGE F JACOBSON, DPM
3816 HOLLYWOOD BLVD #206, 33021
(954)987-0550 OFFICE (954)987-0553 FAX

DEAR PATIENT:

We ask that you please read and sign this form as it concerns you, the patient.

Due to the many changes in insurance policies, it is no longer and easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible; Therefore, we urge you the patient, to please check with your insurance company regarding your coverage. It is **YOUR** RESPONSIBILTY TO KNOW YOUR INDIVIDUAL COVERAGE AND ITS LIMITATIONS. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and insurance company.

If you need a referral from your insurance company or from your primary care physician to be seen in this office, the referral must be present at the time of visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available. We welcome you to call your primary care physician and have your referral faxed to us. Our fax number is (954)987-0553. Please understand that this is a necessity for you to be seen in this office.

If you have a co-payment or out-of-pocket expense, deductible, etc. it must be paid at the time of service.

Many insurance companies must have supplies and services dispensed by a Doctor's office authorized for payment. Our office is extremely busy, and we cannot always get through to your insurance company for authorization. We are often left on hold or told to call back another time. By leaving our office with supplies that that are not authorized, you will be financially responsible if your insurance company denies that payment. Instances whereby your insurance company gives approval for care or services and later reverses its position for whatever reason, you agree to be fully responsible for payment or services rendered.

Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out-of-pocket expenses.

_____ _____

Patient or Guardian Signature Date

_____

Print Name