Paul D. Brooks, D.P.M., P.A.

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. All information will be strictly confidential.

Patient's Name			Date of Birth	Gender	Marital Status
Primary Language:	Race: (Optional)		Ethnicity: (Optional) (Please check) ☐ Hispanic or Latino ☐ Not Hispanic or Latino		
Residence address :			City	State	Zip
Home Phone:	Work Phone:	Mobile Phone:		Patient's Social Security #	
Is it okay to contact you by: ☐ Mail ☐ Phone ☐ Email		Is it ok to leave messages with: (Please check) ☐ You only ☐ Your Spouse ☐ Anyone answering the phone			
Email Address:	Primary Care Physician:		Date last seen:		
Reason for Visit:	How did you hear about our office?:				

Primary insurance company			
Subscriber Name if other than Self	Subscriber birth date	Policy #	Group #
Secondary insurance name			
Subscriber Name if other than Self	Subscriber birth date	Policy #	Group #
Tertiary insurance name			
Subscriber Name if other than Self	Subscriber birth date	Policy #	Group #

Acknowledgment of Receipt of HIPAA - Notice of Privacy Practice

By signing this document, I acknowledge that I have read and understand the **Notice of Privacy Practices** set forth by **Paul D. Brooks, DPM, P.A.** Copies of the current notice are available in our reception area as well as on our website: www.feetareneat.com. I hereby authorize any representative of **Dr. Paul D. Brooks, DPM, P.A.** to talk to the following people regarding my medical treatment.

Emergency Contact Person ____ Relationship ____ Phone #

Contact Person ____ Relationship ____ Phone #

Contact Person ____ Relationship ____ Phone #

Patient or patient's Representative Signature ____ **Print Name** ____ **Date**

Paul D. Brooks, DPM, P.A.

Payment Policy

Thank you for choosing us as your foot and ankle care provider. We are committed to providing you with quality and affordable health care. Please read the following payment policy and feel free to ask us any questions that you may have.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your specific plan benefits.

2. Co-payments, co-insurance and deductibles. All co-payments, co-insurance, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect from patients can be considered fraud. Please help us by paying your out-of-pocket expenses at each visit. We collect the fees as quoted to us by your insurance as of the time of service. You will be responsible for any remaining balance due after insurance has settled your claim.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Patients presenting to our office without a valid referral will be responsible for any charges denied by their insurance company.

4. Proof of insurance. We must obtain a copy of your driver's license or state identification card and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of a claim. Please notify us of any changes to your insurance policy at each appointment.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. Partial payments will not be accepted unless otherwise negotiated. Please be aware that failure to pay, or defaulting on a payment arrangement, may result in your account being referred to collections or small claims court and you and your immediate family members may be discharged from this practice. You will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney fees.

7. Missed appointments. Our policy is to charge $25.00 for missed appointments not canceled within a reasonable amount of time (24 hours) or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

8. Returned checks. Any returned checks will be assessed a fee in accordance with Florida statute 832.05. Failure to pay within 15 days of receipt of notification from our office will result in submission to the Office of State Attorney – Check Division.

Medicare Lifetime Signature on File: (For Medicare Beneficiaries only)

I request that payment of authorized Medicare benefits be made on my behalf to **Paul D. Brooks DPM, P.A.** for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information to determine these benefits payable for related services.

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Patient or Patient Representative Signature Print Name Date

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I, the undersigned, authorize payment of medical benefits to **Paul D. Brooks, DPM, P.A.** for any services furnished me by the physician. I authorize any holder of medical information about me to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. I have read and understand the payment policy and agree to abide by its guidelines.

____

Patient or Patient's Representative Signature Print Name Date

PATIENT HISTORY

*** Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.**

Name: ____ Date: __________

Height: _______ Weight: ________ Shoe Size: _________________

MEDICATIONS : Pharmacy: _______________________ Number: ________________

Medication	Dosage	How Often Taken?	What is it Taken for?

ALLERGIES: (Please list Allergies with type of reaction)

Allergic to: ______________________________Reaction:____________________
Allergic to: ______________________________Reaction:____________________
Allergic to: ______________________________Reaction:____________________
Allergic to: ______________________________Reaction:____________________

MEDICAL HISTORY (* Please check any of the following conditions that you have or have had in the past.)

☐ Diabetes ☐ Fibromyalgia ☐ Tumors ☐ Epilepsy ☐ Nerve Conditions ☐ Heart Problems

☐ Arthritis ☐ Gout ☐ Asthma/COPD ☐ Glaucoma ☐ Stomach Ulcers ☐ Skin Disorders

☐ Tuberculosis ☐ Anemia ☐ Bursitis ☐ Aids (HIV) ☐ Lung Disease ☐ Kidney Problems

☐ Sickle Cell ☐ Stroke ☐ Hepatitis ☐ Osteoporosis ☐ Bleeding Problems ☐ Colitis / Crohn's

☐ Mental Disorders ☐ Poor Circulation ☐ High Blood Pressure ☐ Joint Implants ☐ Thyroid Disease

☐ Rheumatic Fever ☐ Heart Burn / Reflux ☐ Sexually Transmitted Diseases ☐ High Cholesterol

☐ Cancer; type ______________________ Other: ________________________________

☐ Diabetes; What is the name, phone number, and address of the doctor treating you for diabetes? _______________
____

When was your last visit? _____________ What is your average blood sugar reading? _____________

- Are you pregnant? ____Yes ____No How many months? _______

SURGICAL HISTORY

Procedure	Date	Complications

7) Have you ever been hospitalized other than for surgery? ☐ Yes ☐ No Explain_______________________________

____

8) Have you ever had an injury to the lower extremity? ☐ Yes ☐ No Explain __________________________________

____

FAMILY HISTORY

* Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Do you smoke tobacco? ____Yes ____No

If Yes: # packs per day? ____ # cigarettes per day? ____ # of years smoking? ____

If No: Did you ever smoke? ____Yes ____No

If Yes: How long ago did you stop smoking? ___________________

Do you drink alcohol? ____Yes ____No

If Yes: How much? ____< 1 per week ____1-2 per week ____1-2 per day ____more than 3 per day

Recreational drug use

* Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ____Yes ____No

If Yes: What substance and how often used? ____