Foot & Ankle INSTITUTE · MIAMI BEACH

RENEW&RESTORE HEALTH
REGENERATIVE MEDICINE

Dr. Allison Guyen, DPM, FACFA □
Dr. Olivera Jovic, DPM, AACFAS □
Dr. Jeffrey Baker, DO □
Dr. Ivel De Freitas, MD □

Patient Registration

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)	
Sex	Marital Status	Date of Birth		Social Security Number	
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician - Last seen?		Primary Care Physician Phone #	
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance □ Scanned □ Self Pay □

Primary Health Insurance

Insurance Company		Plan	
Policy number #	Group Number	Insured's Employer/School	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Secondary Health Insurance

Insurance Company		Plan	
Policy Number	Group Number	Insured's Employer/School	Insured's Social Security Number

X _____ _____

Signature of Patient or Authorized Guardian Date

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Consent for General Treatment

I here give my permission for Foot & Ankle Institute Miami Beach the practice & Renew & Restore Health to give me Medical Treatment.

I allow the practice to file for insurance benefits to pay for the care I receive.

I understand that:

- The practice will have to send my Medical Record Information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

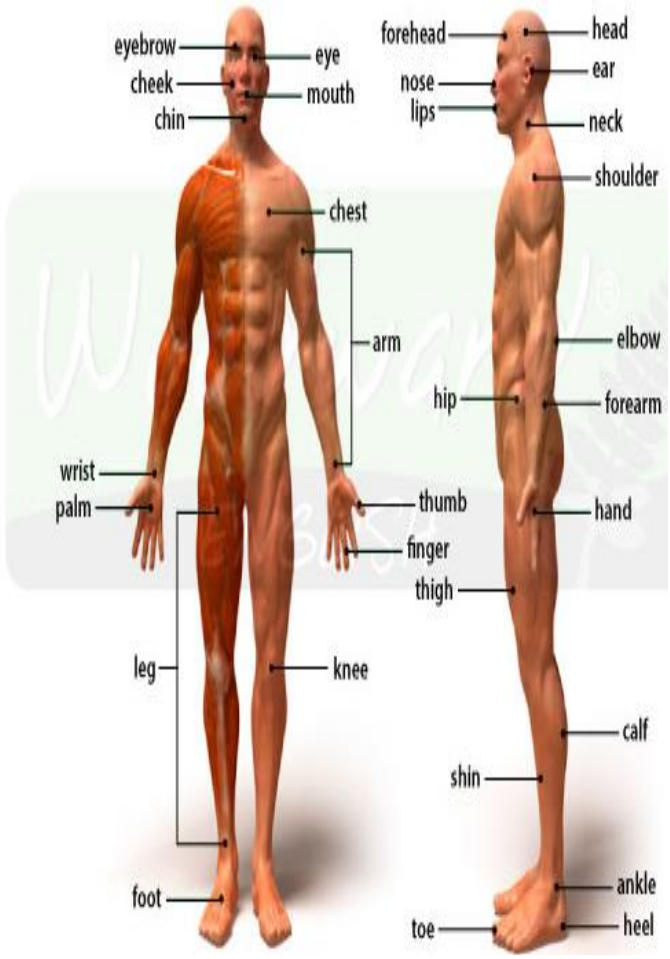
I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with provider.

Patient Name:_____

Signature of Patient or Legal Representative Witness:X_____**Date:**_____

What brings you to the office today?



RIGHT

LEFT

BILATERAL

Pain Assessment

Indicate your level of pain on a scale of 1 - 10.
(10 = worst pain imaginable)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check the symptoms that best describe your problem.

☐ Stiffness ☐ Pain ☐ Instability ☐ Swelling
☐ Numbness ☐ Other _____

Are your symptoms getting...

☐ Better Gradually ☐ Better Rapidly
☐ Worse Gradually ☐ Worse Rapidly

What improves your symptoms?

☐ Rest ☐ Ice ☐ Heat ☐ Motrin/ Aleve

☐ Other:

What makes your symptom worse?

☐ Activity ☐ Cold Other:_____

Weight _____ Height _____ Shoes size _____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No

Do you smoke now?

☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes ☐ No

Do you drink alcohol? **If so, how much per week?** _____

☐ Yes ☐ No

Allergies

Are you allergic to any of the following?

☐ Penicillin	☐ Antibiotics	☐ Latex- Adhesive Tape
☐ Sleeping pills	☐ Aspirin	☐ Iodine
☐ Codeine	☐ Sulfa	☐ Local Anesthetics

Name _____ Reaction _____

Name _____ Reaction _____

Environmental Allergies_____

Surgeries or any procedures

Reason _____ Date _____

Reason _____ Date _____

Patient Past Medical History:

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer _____
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Other:

Family History: (Mother) (M) (Father) (F)

Has anyone in your family ever had any of the following conditions?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Joint Disorder
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Psychiatric Disorders
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder

Mother: Alive or Deceased:

Father: Alive or Deceased:

Women Only

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you currently taking any blood thinners?

Yes_____ **No**_____

What medications/Vitamins are you currently taking?

Medication:	Dosage: (mg)	Frequency: