West Flagler/Sweetwater
35 SW 114th Ave,
Miami, FL 33174, Suite 105
Email: info@miamifeet.com
Office: (305) 480-2045
Fax: (305) 480-2046

INSURANCE INFORMATION

PATIENT INFORMATION – PLEASE PRINT CLEARLY

PATIENT'S LAST NAME	PATIENTS FIRST NAME	PATIENTS MIDDLE NAME	
SOCIAL SECURITY #	BIRTHDATE	AGE	HOME PHONE #
STREET ADDRESS	CITY AND STATE	ZIP CODE	CELL PHONE #
DRIVER'S LICENSE #	MARITAL STATUS	EMAIL:	WORK PHONE #
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	SEX Male ☐ Female ☐	
EMPLOYER'S ADDRESS:	CITY AND STATE		ZIP CODE
SPOUSE (OR GUARDIAN'S NAME IF MINOR)			
1.EMERGENCY CONTACT:(OTHER THAN SPOUSE)	RELATIONSHIP		PHONE #
2.ALTERNATE CONTACT:(OTHER THAN SPOUSE)	RELATIONSHIP		PHONE #
NAME OF INSURANCE:	INSURANCE POLICY NUMBER OR IDENTIFICAITON NUMBER		GROUP NUMBER/NAME
SUBSCRIBER/CARD HOLDER NAME & DOB	NAME OF SECONDARY INSURANCE		GROUP NUMBER/NAME
SUBSCRIBER/CARD HOLDER NAME & DOB OF SECOND INSURANCE			

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with the above listed insurance(s) and assign directly Miami Feet LLC, all insurance benefits, if any otherwise payable to me for services rendered. I authorize release to the indicated insurance company(ies) any medical information needed to determine these payments for related services _____________ Initial

I hereby agree to pay Miami Feet LLC, in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes any co-payment, deductible and/or insurance payments that I may receive as a result of services rendered. Should my account not be paid in a timely manner I understand that I will be held responsible for any further collection and/or attorney fees. An additional fee of $25.00 will be imposed in the event of a returned check or insufficient funds _________ Initial

Treatment Authorization: I hereby authorize treatment by Miami Feet LLC. _________ Initial

Treatment Authorization: I hereby authorize Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Miami Feet LLC for any and all services rendered to me by that provider. I understand that if Medicare denies payment for my foot care that I will be held responsible _________ Initial

To the extent permitted by law, I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for the related services.

Signature of Beneficiary or Guardian	Print Name of Beneficiary or Guardian	Date (mm-dd-yy)

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HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Social Security Number (SSN) ______________________ **Appointment Date** ___________

Full Name ____

Sex: Male ☐ Female ☐ Date of Birth __________________ Primary Language_______________________

Address ___________________________ City ____________ State _______ ZIPCODE _____________

Pharmacy Preference (INCLUDE LOCATION & PHONE NUMBER)

____

Name of Primary Care (Family) Physician ______________________ Phone Number __________________________

Name of Referring Physician _________________________________Phone Number___________________________

Insurance _________________________

CHIEF COMPALINTS:

____
____
____
____
____
____
____

VITAL SIGNS: (to be completed by Miami Feet LLC doctor)

R________ BP____/_____ P_________HT_________WT_______TEMP________ACCU-CHECK___________

PAST SURGICAL HISTORY:

____
____
____
____
____

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HEALTH HISTORY (PAGE 2)

CURRENT MEDICATIONS: Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications) ☐ No ☐ Yes If yes, please list below *include dosages*.

Medication Name	Dosages

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ No ☐ Yes
If yes, please list below.

Name of Medication	*Type of Reaction*

NON-MEDICATION ALLERGIES: Are you allergic to seafood?

☐ No ☐ Yes
If yes, what reaction do you have?____

Are you allergic to things that touch your skin, such as latex, tape, metal?

☐ No ☐ Yes
If yes, which one and what reaction do you have?____

SOCIAL HISTORY:
Alcohol ☐ Smoking ☐ Coffee ☐ Drugs ☐

MARITAL STATUS:
Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated ☐

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HEALTH HISTORY (PAGE 3)

PAST HEALTH HISTORY: Have you ever been *DIAGNOSED* with any of the following problems?

Cancer (type)____________ ☐ No ☐ Yes
What year?___________

Nose and Sinus:
Nasal Allergies ☐ No ☐ Yes
What year?___________

Heart and Blood Vessels:
High / Elevated Cholesterol ☐ **No** ☐ **Yes**
What year?__________

High Blood pressure ☐ **No** ☐ **Yes**
What year?__________

Lungs and Respiratory:
Tuberculosis ☐ **No** ☐ **Yes**
What year?__________

Stomach and Digestive:
Duodenal ulcer ☐ **No** ☐ **Yes**
What year?__________

Hepatitis ☐ **No** ☐ **Yes**
What year?__________

Stomach ulcer ☐ **No** ☐ **Yes**
What year?__________

Kidney and Gender Problems:
Renal failure ☐ **No** ☐ **Yes**
What year?__________

Are you pregnant? ☐ **No** ☐ **Yes**

Mental & Emotional:
Depression ☐ **No** ☐ **Yes**
What year?__________
Anxiety ☐ **No** ☐ **Yes**
What year?__________

Glands, Hormones, and Sugar Control:
Diabetes ☐ **No** ☐ **Yes**
What year?__________

Thyroid deficiency ☐ **No** ☐ **Yes**
What year?__________

Thyroid excess ☐ **No** ☐ **Yes**
What year?__________

Blood & Lymph Node problems:
Anemia ☐ **No** ☐ **Yes**
What year?__________

Allergies, Immune & Infectious Problems:
HIV ☐ **No** ☐ **Yes**
What year?__________

Infectious mononucleosis ☐ **No** ☐ **Yes**
What year?_________

Please add any other health conditions not mentioned:

____
____
____
____

________________________________ ________________________________ ________________
Signature of Beneficiary or Guardian | Print Name of Beneficiary or Guardian | Date (mm-dd-yy)