MIAMI FEET

1401 SW 107th Ave, Suite 301E
Miami, Florida 33174
Email: info@miamifeet.com
Of: (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)

MIAMI FEET

1401 SW 107th Ave, Suite 301E
Miami, Florida 33174
Email: info@miamifeet.com
Of: (305) 480-2045 Fax: (305) 480-2046

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:

_____
_____
_____
_____
_____

MIAMI FEET

1401 SW 107th Ave, Suite 301E
Miami, Florida 33174
Email: info@miamifeet.com
Of: (305) 480-2045 Fax: (305) 480-2046

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 ☐

MIAMI FEET

1401 SW 107th Ave, Suite 301E
Miami, Florida 33174
Email: info@miamifeet.com
Of: (305) 480-2045 Fax: (305) 480-2046

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)