

PODIATRY ASSOCIATES OF FLORIDA - Dr. Harold Cesar, DPM

NEW PATIENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:
Date Of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	SSN:
Address:		
City:	State:	ZIP:
CELL PHONE #:	HOME PHONE #:	EMAIL:
We are required to ask the following questions, however, you may choose not to answer:		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other/Decline
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Other/Decline		

IF PATIENT IS A MINOR - PARENT INFORMATION:

First Name:	Last Name:
Date of Birth:	SSN:

REASON FOR TODAY'S VISIT:

HOW DID YOU HEAR ABOUT US?

Insurance, Internet/Web, Physician: _____, Family/Friend, Other: _____

Check if you have seen any of our other providers within last 3 years:

Dr. Bleau, Dr. Efron, Dr. Herbst, Dr. Lagoutaris, Dr. Matey, Dr. Tillo, Dr. Yant

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY #1:		INSURANCE COMPANY #2:	
Policy Holder Name:		Policy Holder Name:	
Member ID:	Effective Date:	Member ID:	Effective Date:
Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
Policy Holder's Social Security #:		Policy Holder's Social Security #:	
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent		Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	
Is Referral Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Referral Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

YOUR NAME: _____

DOB: _____

TODAY'S DATE: _____

SURGICAL HISTORY (List all your surgeries in the past 5 years)

1.	Year:
2.	Year:
3.	Year:
4.	Year:
5.	Year:

PAST MEDICAL HISTORY (Check any of the following if you still have, or have ever had)

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Tendencies <input type="checkbox"/> Cancer <input type="checkbox"/> Chest Pain <input type="checkbox"/> Circulatory Problem <input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting <input type="checkbox"/> GERD <input type="checkbox"/> Gout <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Problems <input type="checkbox"/> Liver Problems <input type="checkbox"/> Lung Disease <input type="checkbox"/> Melanoma <input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Problems with Anesthesia <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Swelling Ankle/Feet <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Venereal Disease
Can You Take Aleve/Advil/Aspirin Without Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Who Is Your Supervising Provider? (PCP or Endocrinologist) _____	
Women – Are You Pregnant Or Possibly Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Of Last PCP/ENDO Appointment: _____	

CURRENT MEDICATIONS (no medications / list attached)**ANY KNOWN ALLERGIES** (no known allergies)

1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

YOUR SOCIAL HISTORY

Do You Use Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do You Use Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
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YOUR FAMILY HISTORY (Please Indicate **M** for Maternal, **P** for Paternal, or **S** for Sibling)

<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout <input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Stroke
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YOUR NAME: _____ DOB: _____ TODAY'S DATE: _____

PATIENT CONTACTS

YOUR PRIMARY CARE PROVIDER (PCP):	PCP Phone #:
PCP Address:	
PHARMACY:	Pharmacy Phone #:
Pharmacy Address/Location:	
EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone #:	
PLACE OF EMPLOYMENT:	Employer Phone #:
What Type of Work Do You Do?	

YOUR HEIGHT: _____ **YOUR WEIGHT:** _____ **YOUR SHOE SIZE:** _____

PAYMENTS: Co-Pays are due at time of service (which includes Medicare patients). Self-pay patients are required to pay in full at time of service. Your medical claim will be forwarded to your secondary insurance (if any) after payment is received from your primary insurance. You are required to follow the guidelines of your managed care plan. You must have a referral from your primary if your plan requires one. If one is not provided, you can be held financially responsible for service. You will be sent up to three notices for your financial responsibility after payment is received from your insurance company. After the third notice, your account will be forwarded to collections. An additional \$25.00 will be added to your account for all returned checks. You are to inform the doctor's office if there are any changes in your health insurance information. You agree to pay Dr. Cesar, D.P.M. for any remaining balance after insurance payment has been made.

AUTHORIZATION AND ASSIGNMENT: For The Services Rendered And Those About To Be Rendered, I Hereby Assign To Dr. Harold Cesar All Medical And/Or Surgical Benefits Otherwise Payable To Me Under The Above Described Policy Not To Exceed The Charges Made For Such Services. I Further Direct That They Make No Payments To Me. In The Event That I Receive Payment From The Insurance Company I Agree To Endorse Such Payment To Dr. Cesar Immediately. I Understand That I Am Directly And Primarily Responsible To Dr. Cesar For His Usual And Customary Fee For The Services Rendered To Me. I Realize That If My Insurance Company Fails To Pay Or If There Is A Delay (More Than 75 Days) In Their Paying It Is My Sole Responsibility To Promptly Pay My Doctors Bill Directly. I Further Understand And Agree If I Fail To Make Prompt And Timely Payments To Dr. Cesar I Will Be Directly Responsible For Any And All Costs Of Collection Including Filing Fees As Well As Reasonable Attorney Fees. I Hereby Authorize Dr. Cesar To Release To My Insurance Company Any Information Acquired, Including The Diagnosis And The Records In Course Of My Examination And Treatment. I Acknowledge That I Was Provided A Copy Of The Notice Of Privacy Practices And Have Read (Or Had The Opportunity To Read If I Chose) And Understand The Notice.

I CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. **Initial:** _____ **Date:** _____