WORMAN FOOT AND ANKLE ASSOCIATES

PATIENT INFORMATION PACKET

Date: _____

Patient Name: _____ **SSN:** _____

Date of Birth: _____ Sex: Male Female Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Alternate Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (___) _____ Work Telephone: (___) _____

Cell Phone: (___) _____ E- Mail Address: _____

Employer: _____ Occupation: _____

Primary Care **Doctor:** _____ Telephone: (___) _____

In Case of Emergency Please notify: _____

Telephone Number: (___) _____ Cell Phone: (___) _____

IF PATIENT IS A MINOR

Mother's Name: _____ **SSN:** _____

Home Telephone: (___) _____ Cell Phone: (___) _____

Father's Name: _____ **SSN:** _____

Home Telephone: (___) _____ Cell Phone: (___) _____

SPOUSE INFORMATION

Spouse's Name: _____ Date of Birth: _____

Social Security Number: _____

Work Telephone: (___) _____ Cell Phone: (___) _____

WORMAN FOOT AND ANKLE ASSOCIATES

IMPORTANT INFORMATION PLEASE READ

I authorize the release of any information acquired during the course of my treatment or examination to the appropriate insurance companies for payment of medical benefits to the physician for services rendered. I also understand that any services rendered that are not covered or denied by my insurance for any reason will become my responsibility.

Signature _____ Date: _____

IF THE PATIENT IS A MINOR , PLEASE SIGN

I hereby authorize, as the parent or legal guardian, for Dr. Jeffrey Worman, or Dr. Bella Worman, to treat the minor patient.

Signature _____Date: _____

Relationship to minor _____

WORMAN FOOT AND ANKLE ASSOCIATES WELCOMES YOU

NAME_____ AGE_____
HEIGHT_____WEIGHT_____SHOE SIZE_____OCCUPATION_____
PRIMARY CARE PHYSICIAN_____DATE LAST SEEN_____
PHARMACY NAME AND PHONE NUMBER_____
WHO MAY WE THANK FOR REFERRING YOU? _____

WHAT IS YOUR **PRIMARY** FOOT/ANKLE COMPLAINT TODAY? (**ONE** COMPLAINT PER VISIT DUE TO INSURANCE REGULATIONS)

WHEN DID THIS START BOTHERING YOU?

DESCRIBE YOUR PAIN AND RATE IT ON A SCALE FROM 1-10

DOES ANYTHING MAKE IT BETTER OR WORSE?

HAVE YOU HAD ANY PREVIOUS TREATMENT FOR THIS CONDITION?

PLEASE CHECK ALL SYMPTOMS THAT APPLY TO YOU (CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR)

___ FEVER
___CHILLS
___WEIGHT LOSS
___WEIGHT GAIN
___FATIGUE
___DIZZINESS
___HEADACHES
___BLURRY VISION
___CATARACTS
___GLAUCOMA
___RINGING IN EARS
___HEARING AID
___DIFFICULTY SWALLOWING
___SHORTNESS OF BREATH
___BRONCHITIS
___COUGH
___CHEST PAIN
___PALPITATIONS
___LEG SWELLING
__VARICOSE VEINS

___HISTORY OF HEART ATTACK
___MEMORY LOSS
___DEPRESSION
___ANXIETY
___PSYCHIATRIC DISORDER
___SKIN RASH
___EASY BRUISING
___NAIL TEXTURE CHANGE
___TINGLING
___NUMBNESS
___UNSTEADY GAIT
___HISTORY OF BLOOD CLOT
___COLD INTOLERANCE
___HEAT INTOLERANCE
___HISTORY OF STROKE
___WEAKNESS
___ARTHRITIS
___IRREGULAR HEART BEAT
___NOSE BLEEDS
___LOSS OF SENSATION

OTHERS NOT LISTED _____

___HIGH BLOOD PRESSURE
___DIABETES
___HEART DISEASE
___CONGESTIVE HEART FAILURE
___CANCER
___ATRIAL FIBRILLATION
___COPD
___ASHTMA
___HEART BURN
___ARTHRITIS
___RHEUMATOID ARTHRITIS
___GLAUCOMA
___SEIZURES
___FIBROMYALGIA
___DEPRESSION
___ANXIETY
___HIV/AIDS/OTHER STD/STI
___HEPATITIS A/B/C
___HIGH CHOLESTEROL
___DEMENTIA
___PARKINSONS DISEASE
___ANEMIA
___ARTERIAL DISEASE
___KIDNEY DISEASE
___LIVER DISEASE
___THYROID DISEASE HYPER/HYPO

OTHERS NOT LISTED_____

FAMILY HISTORY

MOTHER: MEDICAL HISTORY_____LIVING/DECEASED
FATHER: MEDICAL HISTORY_____LIVING/DECEASED
BROTHER/SISTER: MEDICAL HISTORY_____LIVING/DECEASED

PLEASE LIST ALL PREVIOUS SURGERIES:

PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDING OTC):

ALLERGIES:

SOCIAL HISTORY:
DO YOU SMOKE?
DID YOU EVER SMOKE?
HOW MUCH DID YOU SMOKE?_____PER DAY/WEEK (PLEASE CIRCLE)

DO YOU DRINK ALCOHOL?
WHAT TYPE ALCOHOL?
HOW MUCH DO YOU DRINK? _____ PER DAY/WEEK/MONTH/YEAR (PLEASE CIRCLE)

WHO DO YOU LIVE WITH?

DO YOU USE ANY ASSISTIVE DEVICES TO WALK?

CONSENT FOR PURPOSES OF PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Worman Foot and Ankle for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Worman Foot and Ankle. I understand that diagnosis or treatment of me by the physicians of Worman Foot and Ankle may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Worman Foot and Ankle is not required to agree to the restrictions that I may request. However, we do agree to a restriction that I request in writing, the restriction is binding for Worman Foot and Ankle.

I have the right to revoke this statement, in writing, at any time. This revocation will not be applied retroactively.

My "personal health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This PHI relates to my past, present or future physical or mental health condition and identifies me.

I understand I have the right to review Worman Foot and Ankle Notice of Privacy Practices (NPP) prior to signing this document. The NPP describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of bills or in the performance of health care operations of Worman Foot and Ankle. The NPP also describes my rights and Worman Foot and Ankle duties with respect to my PHI.

Worman Foot and Ankle reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting a revised copy made available at my next appointment.

_____ _____

PRINTED NAME DATE

_____ _____

PATIENT SIGNATURE OR LEGAL GUARDIAN DATE

Jeffrey A. Worman, DPM

WORMAN
FOOT & ANKLE
ASSOCIATES

Bella R. Worman, DPM

Ph: (727) 547-0000
Fax: (727) 547-0008

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Worman Foot & Ankle Associates, it may be medically necessary to obtain a blood, urine, stool, tissue, or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third partyfor cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Worman Foot & Ankle Associates to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____
Signature of patient

_____
Printed Name of Patient

_____
Date

Blue Cross Blue Shield
Aetna
Cigna
United Health Care
UMR
Tricare
Medicare & Medicare Replacements