Precision Foot and Ankle, P.A.
Dr. Dennis Tenenboym, DPM
7800 66th Street N, Suite 207
Pinellas Park, FL 33781

Phone: (727) 399-7167
Fax: (727) 440-8186
Email: precisionfootandankleFL@gmail.com
Website: www.precisionfootandankleFL@gmail.com

New Patient Paperwork

Today's Date: _____/_____/_____

Patient Name:	***Last***	***First***	***MI***	***Date of Birth***	**Sex (Circle): M F**
Home Address:			***City/State***	***Zip***
Home Phone #		***Work Phone #***		***Cell Phone #***
Email Address (Mandatory)				***Primary Language***
Race			***Ethnicity***	

Do you have a legal guardian or healthcare power of attorney? YES NO

If yes, Name:	**Relationship**	**Phone #**
Emergency Contact:	**Relationship:**	**Phone Number:**
Primary Care Doctor:		**Phone:**

Date of Last Primary Care Appointment:

Primary Insurance Company Name	***Policy Number***
Preferred Pharmacy	***Pharmacy Phone Number***

How did you hear about us? ☐ Insurance Company Website ☐ Referral/Primary Care Doctor ☐ Google ☐ Website ☐ Friend ☐ Social Media ☐ Medical Presentation ☐ Newsletter ☐ Other:_____

Current Problem

What is the reason for your visit today?

How long ago did this problem start? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Did the pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe the pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate the pain on a scale from 0 to 10? (Please Circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain possible)

Since the pain began, has it: ☐ stayed the same ☐ become worse ☐ improved

What makes your pain or problem worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress shoes ☐ High Heels ☐ Flat Shoes ☐ Closed Toe Shoes ☐ Running ☐ Other:_____

What makes the pain or problem feel better?

What treatments have you had for this problem?

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What treatments have you tried for this problem?

Was this problem caused by an injury? ☐ YES (describe) _____ ☐ NO

If so, was this injury work-related? ☐ YES ☐ NO

Medical History

Do you have any of the following medical problems? ☐ Anemia ☐ Anxiety ☐ Back pain ☐ Bleeding problems ☐ Blood clots ☐ Cancer: type _____ ☐ COPD ☐ Depression ☐ Diabetes: type_____ last hemoglobin A1c % _____ ☐ Fibromyalgia ☐ Gout ☐ Heartburn/Reflex ☐ Heart Failure ☐ Heart Problems ☐ Heart Attacks ☐ HIV/AIDS ☐ High Blood Pressure ☐ Joint Implants ☐ Kidney Problems ☐ Liver Problems ☐ Migraines ☐ Neuropathy ☐ Open Sores ☐ Osteoporosis ☐ Pneumonia ☐ Polio ☐ Rheumatoid Arthritis ☐ Sickle Cell Disease ☐ Skin Problems ☐ Sleep Apnea ☐ Stomach Ulcers ☐ Stroke ☐ Thyroid Disease ☐ Tuberculosis

Other Medical Problems Not Listed Above:

Surgical History – Please List All Prior Surgeries and the Date of The Surgeries

1.	4.
2.	5.
3.	6.

Family History – List Any Relatives With the Following Medical Problems:

Diabetes _____	Stroke _____
Cancer _____	Thyroid Disease _____
Heart Disease _____	Rheumatoid Arthritis _____
High Blood Pressure _____	Other: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Alcohol Use: ☐ Never ☐ No Longer Use ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Tobacco Use: ☐ Never ☐ Quit – How long ago? _____ ☐ Smoke _____ Packs/Day for _____ Years

Recreational Drugs:

Employer:	**Occupation:**

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How much do you exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Several Times Per Week ☐ Daily

Hospitalizations – Please List All Hospitalizations Within the Past 5 Years

1.	4.
2.	5.

Allergies: Please List All Of Your Allergies Below:

Medication Allergies:	**Other Allergies:**

Medications – Please List All Medications You Are Currently Taking (Including prescriptions, over-the-counter and herbal supplements)

Medication	*Dose*	*How Often Do You Take?*	*Medication*	*Dose*	*How Often Do You Take?*

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Review of Systems
For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.
Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other:_____
Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:_____
C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____
Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____
GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:_____
GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____
MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____
Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____
Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:_____
Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____
Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____
Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____
Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____
Peripheral Vascular Disease ❑ No Problems Intermittent claudication, leg cramps, varicose veins

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

Patient Name (Print here)	***Signature***	***Date***

Physician Signature	***Date***

Over 70% of our patients bring in their children. Children have various foot problems including plantar warts and flat feet. Did you know that most foot problems are genetic? It is always good to have your child looked at. An ounce of prevention is worth a pound of cure.

☐ **I would like my family members checked for any foot and/or ankle problems.**

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Patient First Name	*Last Name*	*Date of Birth* Month / Day / Year
Street Address		Legal Guardian Name if different from patient
City	*State* / *Zip*	Phone Number

AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION

I, the patient, legal guardian or health care surrogate, hereby authorize Precision Foot and Ankle, P.A. doctors and staff to examine and treat the aforementioned, if necessary. I understand that this consent may be withdrawn at any time and withdrawal of consent must be in writing to the Precision Foot and Ankle, P.A. doctors and staff. I understand that photographs may be taken by Precision Foot and Ankle PA doctors and staff for documentation purposes to be included as part of the medical record.

The patient, legal guardian or health care surrogate authorizes Precision Foot and Ankle PA doctors and staff to disclose appropriate and necessary clinical information to other facility staff for the purpose of treatment. Clinical information can be released to family members listed below for purposes of treatment:

1.
2.
3.

ASSIGNMENT OF BENEFITS

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible. You agree to allow Precision Foot and Ankle, P.A. to bill your insurance directly and receive payments for services rendered. You may be responsible for any non-covered services and your portion of payments that are patient responsibility.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please feel free to contact us.

If you believe that your privacy rights have been violated, you may file a complaint with our HIPPA Privacy Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Requested medical records will be provided *within 30 days of the date of request.*

AWKNOWLEGEMENT OF AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND NOTICE OF PRIVACY PRACTICES

I, the patient or legal representative have reviewed the above information and agree to allow Precision Foot and Ankle, P.A. doctors and staff to proceed with treatment of the above-mentioned payment and agree to the above terms of service.

Signature of Patient or Legal Representative	***Date***

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Financial Policy

Welcome and thank you for choosing our office for your foot and ankle care needs. In our effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read our Financial Policy.

If at any time you have a question regarding our office policies, do not hesitate to contact us and we will be happy to help you.

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and also a provider for most PPO and HMO insurance plans in our area. It is your responsibility to make sure we are on your insurance plan. If your insurance requires a referral, it is your responsibility to make sure that it is in place prior to your appointment. We will be glad to assist you if you need help.

We will bill your insurance company as a courtesy to you. **All co-payments are due at the time of your visit. If you have an unmet deductible we pre-collect 60% of the charges incurred that your insurance will apply towards your deductible.**

If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed to you and due at that time.

Balances/Collection Fees: If balances are not paid within **30 days** from the statement date a **$12.00 rebilling fee** will be added to each additional statement sent for the unpaid balance. A consistent attempt will be made to collect outstanding account balances. Past due accounts more than **90 days** will be turned over to our collection agency and a **30% fee** of the balance due will be added to cover collection costs. I also understand that failure to pay my bill implies discontinuation of podiatry services.

Complete payment for all podiatry soft goods, medical products and supplies are due at the time they are dispensed.

A 24-hour notice is requested for cancellation of appointments. If you fail to show for an appointment you personally may be charged a **$50.00 no-show fee**. We will try to accommodate you in rescheduling your appointment as soon as possible.

I have ready the above policy and understand my financial responsibility to Dr. Tenenboym for medical services rendered. I agree to pay Dr. Tenenboym any balance due/or unpaid by my insurance carrier for myself or the below named person.

Financially Responsible Party:

Patient Name: _____ Signature: _____

Parent or Authorized Representative: _____ Date: _____