Superior Foot, Ankle & Wound Care - New Patient Form - Please Print

Email: admin@superiorpodiatry.com

Full Name:_____ **Preferred Name:**_____

DOB: ___/_____/____ **Sex:** ☐ Male ☐ Female **Race:** _____

Address:_____

Phone Number:(_____)_____ **Email:**_____

Would you like text/email reminders? ☐ yes ☐ no

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

Emergency Contact:_____ **Phone:**(____)_____ **Relation:**_____

How did you hear about our practice?
☐ Internet ☐ Family/Friend ☐ Insurance ☐ Other ☐ Patient of Practice:_____

Assignment of Benefits & Authorization To Release Information:

If I am entitled to benefits under the Medicare, Medicaid, or any insurance policy or other health benefits plan, (covering me or anyone legally responsible for me), in consideration for services provided to me by Superior Foot, Ankle & Wound Care. I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered by to me. I authorize payment of benefits to be applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, durable medical equipment and any charges for services deemed to be: non covered, not pre-certified, or not pre-authorized by my insurance plan.
____(initial) I give my consent for examination and treatment by Superior Foot, Ankle & Wound Care.

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. it is my responsibility to inform the doctor and the staff of any changes to my medical stats.

Responsible Party Signature: (if insured)_____ ***Date:*** _____
Responsible Party Signature: (if self pay)_____ ***Date:***_____

If not signed by the patient please indicate relationship to the patient:
Relationship:_____ ***Date:***_____

Release of Protected Health Information:

Name:_____ **Phone:**(____)_____

Relation: ☐ Spouse ☐ Parent ☐ Child ☐ Friend ☐ Other

Primary Care Provider:_____ **Phone:**(_____)_____

Pharmacy:_____ **Phone:**(_____)_____

Please Indicate if you have a problem with the following:

☐ Aids/HIV ☐ Blood Clot ☐ Cancer ☐ Coronary Artery Disease ☐ Diabetes ☐ Dialysis ☐ Edema

☐ Epilepsy/Seizures ☐ Fibromyalgia ☐ Gout ☐ Hepatitis ☐ High Blood Pressure ☐ Hyper/Hypo Thyroid

☐ Kidney Disease ☐ Leg/Foot Ulcer ☐ Liver Disease ☐ Organ Transplant ☐ Osteoporosis ☐ Pacemaker

☐ Rheumatoid Arthritis ☐ Seasonal Allergies ☐ Stroke ☐ Substance Abuse ☐ Varicose Vein

☐ Vascular Disease

Do you have artificial joints?_____

Do you have any past FOOT surgeries?_____

Have you had any past surgeries not listed above?_____

Are you taking blood thinners? ☐ yes _____ ☐ No

Current Medications:_____

_____

Are you allergic to:

☐ Penicillin ☐ Sulfa ☐ Latex ☐ Aspirin ☐ Tylenol ☐ Vicodin ☐ Codeine ☐ Ibuprofen ☐ Betadine(Iodine)

☐ Other_____

☐ No known drug allergy

Social History:

Do you smoke? ☐ yes ☐ no **Did you smoke?** ☐ yes ☐ no **If yes, how long?**_____

Family History:

Mother: ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis

Father: ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis

1690 US 1 Hwy S, Suite C
St. Augustine, Fl 32084

Superior Foot+Ankle & Wound Care

9 Pine Cone Drive #101

Palm Coast, FL 32137

Phone: 904-436-8001 • **Fax:** 904-376-7761

Appointment Cancellation Policy

Dear Patient, Parent or Guardian of: **Date:_____**

Superior Foot, Ankle & Wound Care has instituted an Appointment Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

We are committed to the highest quality of care for all of our patients; therefore, we schedule all appointments in advance and make every attempt to confirm them.

1. Please provide our office a **24-hour notice** in the event that you need to cancel or reschedule.
2. **A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, may be assessed a $50 fee.**
3. The fee is not billable to your insurance.
4. As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancelation policy remains in effect.
5. The 3rd missed appointment in a calendar year may result in the dismissal from the practice.

To ensure we do the best job possible keeping you informed about your appointments in a timely manner, we request that you frequently check your contact information we have in our files. Our staff is dedicated personally and professionally, to give you the concern, respect and care that makes our office a comfortable place to visit. We ask that you please call if you can not keep your scheduled appointment time.

By signing below, you have read, and understand this agreement.

Patient Name:_____ DOB:_____

Signature:_____ Relationship:_____