YANSSEL DELGADO DPM, P.A.

630 East 49th Street Hialeah, FL 33013
Ph: (305)819-9240 / (305)819-9239
Fax: (305)819-9241
www.delgadopodiatricsurgeon.com

NEW PATIENT REGISTRATION FORM

/ /	Primary care doctor:		
	Address:	Phone:	Fax:
Today's Date	Last visit (month/year):		

PATIENT INFORMATION

Last Name:	First Name:	MI:	Gender: F ☐ M ☐
DOB: _____/_____/_____ SSN: _____	Marital Status: (Please circle one) Single / Married / Divorced / Widowed	Race:	Language: English / Spanish
Street:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	
Email:			

IN CASE OF EMERGENCY

Person to contact: _____ _____ _____ _____
Name Last Name Relationship Emergency Contact Phone

EMPLOYMENT INFORMATION

Employer:	Employment status:	Full Time Part Time	Retired Student	Disable Unemployed
Employer Address:	Employer Phone:			

INSURANCE INFORMATION

Primary insurance company:	Policy #:	Group #:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____		
Secondary insurance company:	Policy #:	Group #:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____		
If patient is a MINOR, please fill in responsible parent or gaurdian:		
Parent/Guardian Name:	DOB:	SSN:
Employer:	Phone Number:	

Have you ever seen a podiatrist? ☐ Yes ☐ No if Yes, when (month/year)?

Please complete the following: Height: _____ Weight: _____ Shoe size: _____

Whom may we thank for referring you? _____

The above information is true to the best of my knowledge.

Patient / Guardian signature _____ Date: _____

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PODIATRY NEW PATIENT FORM

Patient Name: _____

Please describe your problem (include date of injury if applicable) _____

_____

_____

ALLERGIES

Please check all allergies:

Medications: _____

Foods: _____

Others: _____

What type of reactions have you experienced? _____

MEDICATIONS

Medication	Dosage	Frequency	Medication	Dosage	Frequency

PHARMACY INFORMATION

Name		Telephone	
Address			

SURGICAL HISTORY

Surgical Procedures / Serious Injuries / Illnesses	Year	Hospital

Do you currently smoke? Yes_____No_____ How many packs per day? _____ How many years?_____

Did you smoke previously? Yes_____No___ How many packs per day? ___ How many years?_____ Year quit: _____

Number of caffeine drinks per day? _____ Amount of alcohol consumed per week? _____ Do you take any illegal drugs? _____

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray , examination or photographs of infections as necessary.

Patient Signature: _____ Date: _____

I have personally reviewed the above information

Physician Signature: _____ Date: _____

PAYMENT POLICY

Thanks for choosing our practice. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it and ask us any questions that you may have before signing in the space provided. A copy will be provided to you upon request. Thanks for being our patient.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCED. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: Certain insurance plans with which we are contracted require referral authorization from your primary care physician/ pediatrician. If we have not received a referral prior to your arrival at the office, we have a telephone for you to use to call your primary care /pediatrician physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Co- payments and Deductible All co-payments, deductibles & co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance All patients must complete the patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. Failure to provide the correct insurance information in a timely manner may result in the balance of a claim being transferred to your personal responsibility.

Coverage Changes If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment We accept payment by cash, Visa, MasterCard, American Express and Discover.

Patient Statements If you have unpaid balance you will receive a statement by mail every two weeks. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to a collection agency for collections. All payments go towards the oldest outstanding balance.

No Show Fee Please cancel/reschedule your visits with 24 hours notice or a fee of $25 will be charged.

Collection Fees: Balances that have not had a payment made within 90 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33.33%.

Patient'sName:_____

ResponsibleParty:_____

Signature:_____ **Date:**_____

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PRIVACY POLICY SUMMARY

A full Notice of Privacy Practices containing a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information is available upon request. Please refer to that notice for further information.
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 closely 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 for a nominal fee;
- 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 receive notice of our privacy practices.
- If you have a question, concern or complaint regarding our privacy practices, please note in writing below.

Name:_____Signature:_____Date:_____