YANSSEL DELGADO DPM, P.A.

630 E 49th St, 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: Other	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 ☐ Retired ☐ Disable ☐ Part Time ☐ Student ☐ 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)?

Cardiologist: _____Last Visit:_____ Endocrinologist:_____Last Visit:_____

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: _____

Clear Form

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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 reactionshave 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: _____

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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:_____

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient name: _____ DOB: _____

Our office appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. These payments are due at time of treatment. Many Insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

I have read the above policy regarding my financial responsibility to Dr. Yanssel Delgado DPM, P.A. for providing Podiatric Medical and Surgical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Yanssel Delgado DPM, P.A., the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient / Guarantor Signature: _____ Date: _____

SELF-PAY PATIENT

I do not have health insurance and will be responsible for services rendered here at Yanssel Delgado DPM, P.A. office. I agree to pay Yanssel Delgado DPM, P.A. the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient / Guarantor Signature: _____ Date: _____

LITIGATION PATIENTS

To all litigation patients who have prior approval from our office treatment: Patients who are being treated with understanding that their charges will be held in pending until the settlement of their court case must furnish this office with a Letter of Guarantee from their attorney prior to initial treatment and sign agreement stating that the patient clearly understands that the balance outstanding in our office is due upon settlement wheter or not the suit is in favor of the patient or the party or parties involved. This balance becomes **due in full** upon settlement of the case and is the sole responsibility of the patient. NO PATIENT WILL BE TREATED WITHOUT A SIGNED LETTER OF GUARANTEE IN OUR FILES " EXCEPT ON CASH BASIS ONLY"

Patient / Guarantor Signature: _____ Date: _____

WORKER'S COMPENSATION PATIENTS

If Worker's Compensation insurance coverage can be verified, all patients treated by our office for injuries sustained while on the job will have their treatment charges billed directly to the insurance carrier monthly. Prior to treatment under this classification, employment, insurance coverage and all information pertaining to your claim will be verified. It is the responsibility of the patient to furnish our office with the necessary information and name(s) in order for out office to verify coverage. ***NOTE: If your Worker's Compensation claim is in litigation, a Letter of Guarantee from your attorney will be necessary in order for this office to hold your account balance in pending until settlement is reached, otherwise you will be treated on a cash only basis. Our office will also request your personal insurance carrier information. If a settlement is reached and it is not your advantage, payment will then be DUE INMEDIATELY from the patient. If you cannot pay the balance in full at the time, you will be required to make monthly payments agreed upon with our office and a signed agreement will be requiered in order to avoid legal action. IT IS THE RESPONSIBILITY OF THE PATIENT TO PAY THE TREATMENT CHARGES AT THE TIME OF A SETTLEMENT WHETER OR NOT THE SETTLEMENT IS IN YOUR FAVOR.

Patient / Guarantor Signature: _____ Date: _____

Clear Form