PATIENT HISTORY FORM

South Miami Podiatry
Leonardo Zayas-Bazán, DPM

Patient Name _____ Age_____ DOB_____

Current Weight _____ Height _____ Shoe Size _____

PAST MEDICAL HISTORY:

Are you Diabetic? ☐Yes ☐No Do you use insulin? ☐Yes ☐No Diagnosis Date: _____ Last A1C Reading: _____

Check each line	Yes	No
Amputation	___	___
Anaphylactic Reaction	___	___
Anesthesia Reaction	___	___
Anxiety Disorder	___	___
Arthritis	___	___
Asthma	___	___
Atrial Fibrillation	___	___
Back Pain	___	___
Blood Clot History	___	___
Broken Bone	___	___
Location_____		
Cancer	___	___
Circulation Problems	___	___
Colitis	___	___
Congestive Heart Failure	___	___
COP/Emphysema	___	___
Cysts	___	___

Check each line	Yes	No
Cystic Fibrosis	___	___
Depression	___	___
Fibromyalgia	___	___
Gout	___	___
Heart Disease	___	___
Hepatitis	___	___
High Cholesterol	___	___
High Blood Pressure	___	___
HIV/AIDS	___	___
Hyperthyroidism	___	___
Hypothyroidism	___	___
Irritable Bowel Syndrome	___	___
Kidney Disease	___	___
Large Scars/Keloids	___	___
Liver Condition	___	___
Melanoma	___	___
Mitral Valve Prolapse	___	___

Check each line	Yes	No
Menopause	___	___
Neuropathy	___	___
Osteopenia	___	___
Osteoporosis	___	___
Pacemaker	___	___
Peripheral Vascular Disease	___	___
Psoriasis	___	___
Pulmonary Embolism	___	___
Reflux/Heartburn	___	___
Rheumatoid Arthritis	___	___
Seizure Disorder	___	___
Skin Ulcers	___	___
Sleep Apnea/CPAP	___	___
Stomach Ulcers	___	___
Stroke	___	___
Tuberculosis	___	___
Other _____		

List all medications you take **INCLUDING THE DOSAGE AND FREQUENCY** (include aspirin, birth control pills, over the counter medications and supplements) **IF YOU HAVE A LIST, WE CAN MAKE A COPY.**

Medication	Dosage	How Often?	Medication	Dosage	How Often?

Allergies: _____

Previous Surgeries: _____

SOCIAL HISTORY: (Check)

Smoking Status:	O Non-smoker	O Former Smoker	O Current Smoker
Alcohol Use:	O Non-Drinker	O Social Drinker	O Daily Use
Illicit Drug Use:	O Never Used	O Former User	O Current User of: _____

REVIEW OF SYSTEMS: Please mark any CURRENT symptoms you are experiencing:

Cardiovascular	O Chest pain O Shortness of breath	O None
Motor	O Difficulty walking O Weakness (right left both) O Morning joint stiffness	O None
Neurological	O Numbness in feet O Leg pain O Para theses (nerve sensations)	O None
Dermatological	O Rash O Masses O Skin color changes O Itching	O None
Vascular	O Calf/leg cramps O Swelling O Cold fingers/toes O Cold intolerance	O None

*__Note__: We may take x-rays during your visit. Please inform us if there is any chance you may be pregnant. Medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications. If you would like a copy of your continued care document from today, please inform the front office.

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

Signature: _____ Date: _____

PATIENT DEMOGRAPHIC FORM

South Miami Podiatry
Leonardo Zayas-Bazán, DPM

First Name/Middle I	Last Name	Date of Birth	Sex

Address	City, State, Zip Code	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Cell Phone	Home Phone	Email Address

Primary Care Doctor Name / Phone Number	Preferred Language ☐English ☐Spanish ☐Creole ☐Other_____

Race/Ethnicity ☐Hispanic ☐White – Non-Hispanic ☐Black – Non-Hispanic ☐Asian/Pacific Islander ☐American Indian/Alaska Native ☐Other: _____	How did you hear of us? ☐Friend ☐Google ☐Doctor ☐Event ☐ Other:_____

Reason for Today's Visit

Pharmacy Name / Pharmacy Phone/Address	Preferred Contact Method ☐Phone ☐Text ☐Email ☐Mail

Emergency Contact Name	Phone Number	Relationship

Do we have permission to:

1. Send messages on your voicemail, text, & email? - - - - - - - - - - - - ☐ Yes ☐ No
2. Discuss your medical conditions with a designated person? - - - - - ☐ Yes ☐ No

If YES to question 2, please provide name and relationship? _____

Is your visit due to a job-related injury or automobile accident? ☐ Yes ☐ No

For patients under age 18, Parent(s) or Legal Guardian Contact:

Name Phone Relationship

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Leonardo Zayas-Bazan, DPM.

I acknowledge that I am financially responsible for payment, whether covered by insurance or not.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

South Miami Podiatry
Leonardo Zayas-Bazán, DPM

Our commitment here at South Miami Podiatry is to serve our customers with professionalism and care, always being sure to protect the privacy and security of all protected health information.

While serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find if necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing agency.
- During health care operations, we may need a second opinion.

We here at South Miami Podiatry are committed to comply with all Federal, State and Local Laws and regulations regarding Privacy Practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization of the individual. This written authorization may be revoked at any time by individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to bring this to our attention.

PAYMENT POLICY

Payments are due at the time of service unless payment arrangements have been requested and approved in advance. 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 your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: As our patient, you are responsible for obtaining all authorizations/referrals required by your insurance plan from your primary care physician/pediatrician. If you are unable to provide the referral at your scheduled appointment time, you will be rescheduled.

Co-payments and Deductibles: 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. 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.

Patient Statements: If you have an 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. At our discretion, a fee equal to the cost of your office visit will be charged.

I have read and understood the above ***NOTICE OF PRIVACY PRACTICES and PAYMENT POLICY:***

_____	_____	_____
Name	Signature of Patient or Guardian	Date

South Miami Podiatry
Leonardo Zayas-Bazán, DPM

PHOTO CONSENT AND RELEASE

I consent for photographs and/or video images to be taken of me by Dr. Zayas-Bazan, DPM or a representative.

By consenting to photographs and/or video, I understand I will not be compensated from any party. Although photographs and/or video will be used without identifying information, I understand it is possible someone may recognize me.

I acknowledge that my participation is voluntary and agree that use of any photographs and/or video confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please check YES or NO below)

☐YES ☐NO For educational purposes (medical teaching/training).

☐YES ☐NO My photographs/video will only be used as part of my medical record.

☐YES ☐NO For marketing/advertising (website, print/digital, social media).

I hereby release Dr. Leonardo Zayas-Bazan, DPM and his employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation. By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via a written request submitted to Dr. Leonardo Zayas-Bazan or by completion of a new form.

_____	_____	_____
Patient Name	Signature	Date