FOOT, ANKLE & LEG SPECIALISTS OF SOUTH FLORIDA, INC.

☐ Robert H. Sheinberg, D.P.M., Foot & Ankle Surgeon
☐ Carlo A. Messina, D.P.M., Foot & Ankle Surgeon
☐ Michael M. Cohen, D.P.M., Foot & Ankle Surgeon
☐ John D. Goodner, D.P.M., Foot & Ankle Surgeon

☐ 1600 Town Center Blvd., Weston, FL 33326 (954) 389-5900
☐ 17842 NW Second St., P. Pines, FL 33029 (954) 430-9901
☐ 220 SW 84th St. Ste. 102., Plantation, FL 33324 (954) 720-1530

The Doctors and their staff would like to welcome you to this office.
Please assist us in answering the following questions to help us become better acquainted with you.

PATIENT INFORMATION: (PLEASE PRINT)

Date _____

Name (First)_____ (MI) ____ (Last) _____ Marital Status_____

Address _____ Apt. No.____ City_____ State____ Zip_____

Home Phone _____ Cell. _____ E-Mail _____ ☐ Opt in ☐ Opt out

Driver's License # _____ Driver's License State _____

DOB ___/___/____ Age _____ Sex ____ Social Security No _____ Occupation _____

Employer/School _____ Business Phone _____

Address_____ Apt. No.____ City_____ State____ Zip_____

Permanent Resident Yes____ No____ If no, please list second address:

Address_____ Apt. No.____ City_____ State____ Zip_____

If patient is a minor- please complete:

Father's Name _____ Mother's Name _____

Employer_____ Employer_____

Position_____ Phone_____ Position_____ Phone_____

Please list the name of a person to contact in case of an emergency other than a spouse or parent:

Name_____ Relationship_____ Phone_____

Address_____ Apt. No.____ City_____ State____ Zip_____

PRIMARY INSURANCE: Company's Name_____ Phone _____

Address_____ Apt. No.____ City_____ State____ Zip_____

ID#_____ Group #_____ Is this an Employer's Plan? Yes___ No___

Insured's full name _____ Insured SS#_____ Insured DOB _____

Relationship to Insured (self, spouse, child, other)_____

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION/FINANCIAL AGREEMENT. I, the undersigned, knowing the patient, (minor) and/or self, is suffering from a condition requiring health care, diagnosis and/or medical treatment hereby voluntarily agree to such diagnostic procedure and health care and assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, insurance company or Worker's Compensation. I request that payment to insurance benefits made on my behalf be paid directly to the doctor. I assume full financial responsibility for all debts incurred in any treatment and follow-up care received. I understand that any unpaid patient balances will be assessed at an interest rate of 1.5% per month. Any patient assigned to collections will be assessed a 25% surcharge on the balance.
I understand that no guarantee or assurance has been made as to the results of the procedure or treatment and that it may not cure the condition. It is the patient's responsibility to obtain authorization from their Primary Care Physician or insurance company (if required by your insurance company) prior to services being rendered.

*I acknowledge that I was provided a copy of Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understand the Notice.

* Our practice has made a strong effort to keep our costs down in an attempt to consider taking all types of health insurance including Medicare and Medicaid. This allows us to provide medical services to our community. With that effort, we are sorry but find it necessary to charge patients **$35** for all appointments that were "NO SHOWS". This means no effort was made to cancel or reschedule the appointment. The charge will be applied to your outstanding balance.

Patient's or Legal Guardian's Signature _____ Date _____

MEDICAL HISTORY

Primary Care Doctor_____ Phone No. _____ Date of Exam: _____

Describe the condition that brought you to this office:_____

_____

_____

If auto accident, date of accident_____ Previous care for this condition? ◻ Yes ◻ No

Dr._____ Date_____

Whom may we thank for referring you to us?_____

◻ Davie Town Times ◻ Plantation Town Times ◻ Miramar Town Times ◻ Pembroke Pines Town Times
◻ Our City Weston ◻ Weston Lifestyle ◻ Estate Lifestyle ◻ Hospital
◻ Insurance Company ◻ SF running forum ◻ Urgent Care ◻ Viva
◻ Other_____

MEDICAL: Height _____ Weight _____ (Please check any of the following if it pertains to you).

◻ Diabetes ◻ Heart Attack ◻ Seizures ◻ Scar Former ◻ High Blood Pressure
◻ Angina/Chest Pain ◻ Phlebitis ◻ Thyroid Disorder ◻ Angioplasty ◻ Hepatitis
◻ Kidney Disorder ◻ Bleeding Disorders ◻ Stroke/TIA's ◻ Ulcers ◻ Asthma
◻ Mitral Valve Prolapse ◻ Circulation Disorder ◻ Anemia ◻ Hiatal Hernia ◻ Cirrhosis
◻ HIV ◻ Myocardial Infarction ◻ Deep Vein Clot ◻ Other: _____
◻ Pulmonary Embolism ◻ High Cholesterol ◻ Coronary Stent _____

ALLERGIES:

◻ Penicillin ◻ Aspirin ◻ Codeine ◻ Novocaine ◻ Iodine ◻ Tape
Other:_____

MEDICATIONS: (Please include Aspirin, Tylenol, Vitamins and Birth Control Pills).

1._____ 2._____ 3._____ 4._____ 5._____

PREVIOUS SURGERIES & HOSPITALIZATIONS:

1._____ 2._____ 3._____ 4._____

FAMILY HISTORY: ◻ Diabetes ◻ High Blood Pressure ◻ Bleeding Tendencies ◻ Other _____

SOCIAL HISTORY: ◻ Smoking ◻ Alcohol ◻ Recreational Drugs

Do you currently (or in the past) suffer from any of the following?

Podiatric History:

◻ Flat Feet
◻ Pain or fatigue in feet & legs with activity
◻ Heel or arch pain (child or adult)
◻ Numbness and tingling in feet & toes
◻ Pain in feet getting out of bed
◻ Bunions (prominent foot bones)
◻ Crooked toes (hammertoes)
◻ Ankle swelling & stiffness
◻ Ankle instability (easy twisting injuries)
◻ Leg pain (shin splints)
◻ Growing pains
◻ Difficulty running
◻ Poor coordination with sports
◻ Intoe or out-toe gait
◻ Abnormal foot posture (clubfoot, metadductus)
◻ Achilles tendon pain

Orthopaedic History:

◻ Neck pain (cervical discogenic pain)
◻ Lower back pain (lumbar pain or sciatica)
◻ Shoulder pain (bursitis) (rotator cuff tendinitis) (impingement)
◻ Shoulder (rotator cuff) tear
◻ Shoulder instability (labral tear) (dislocation)
◻ Tennis elbow/Golfer's elbow
◻ Chronic wrist pain
◻ Carpal tunnel syndrome (numbness and tingling)
◻ Trigger finger (catching or locking fingers)
◻ Hip or knee arthritis
◻ Knee pain and swelling (cartilage or meniscal tear)
◻ Knee instability or looseness (ACL ligament tear)
◻ Bursitis (shoulder, elbow, hip or knee)
◻ Thigh (hip) pain (that refers down the leg)
◻ Kneecap (patella) instability (subluxation)

South Florida Institute of Sports Medicine

Foot, Ankle & Leg Specialists of South Florida, Inc.

PODIATRY • ORTHOPEDICS • REHABILITATION

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Fellow American College of Foot & Ankle Surgeons
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- Children's Foot, Ankle and Leg Deformities
- Flat Feet Adults and Children
- Gait Disturbances
  - In-toe
  - Out-toe
  - Toe Walkers
- Fracture Care Foot, Ankle and Leg
- Total Ankle and Big Toe Joint Replacements
- Reconstructive Foot, Ankle and Leg Surgery
- Sports Injuries
- Heel and Arch Pain
- Arthroscopic Foot and Ankle Surgery
- Achilles Tendon
  - Ruptures
  - Tendonitis
- Bunion Correction
- Hammertoe Correction
- Ligament Injuries Ankle and Lisfranc
- Reconstructive Joint Surgery
- Arthritis Surgery
- Skin Surgery
- Toenail Surgery
- Diabetic Foot Care and Charcot Reconstruction
- Nerve Injuries
  - Neuromas
  - Tarsal Tunnel
  - Entrapments

ATTENTION ALL PATIENTS:

IT IS YOUR RESPONSIBILTY TO KNOW YOUR INSURANCE COVERAGE!

ALL INSURANCE PLANS AND POLICIES HAVE DIFFERENT BENEFITS, COPAYMENTS, CO-INSURANCES, DEDUCTIBLES, ETC.

IF YOU ARE UNSURE OF YOUR BENEFITS PLEASE CALL THE CUSTOMER SERVICE PHONE NUMBER ON YOUR INSURANCE CARD AND HAVE AN INSURANCE REPRESENTATIVE EXPLAIN THESE BENEFITS TO YOU.

THANK YOU!

I HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT NAME:_____

PATIENT SIGNATURE:_____ **DATE:**_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ, IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

PATIENT PRINTED NAME:_____

PATIENT/AUTHORIZED REPRESENTATIVE (IF APPLICABLE):

PATIENT SIGNATURE:_____ **DATE:**_____

CANCELATION/NO SHOW POLICY

PATIENT NAME:_____ **DOCTOR:**_____

DEAR PATIENT,

PLEASE BE ADVISED THAT FOOT, ANKLE AND LEG SPECIALIST OF SOUTH FLORIDA REQUIRES 24 HOUR NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT WITH YOUR DOCTOR OR PHYSICAL THERAPIST. IF YOU FAIL TO CANCEL YOUR APPOINTMENT WITHTIN 24 HOURS OF THE APPOINMENT TIME, YOU WILL BE BILLED A $35 FEE.

PATIENT SIGNATURE:_____ **DATE:**_____

WESTON	1600 Town Center Blvd., Suite C, Weston, FL 33326	Ph: 954-389-5900	Fax: 954-389-5751
PEMBROKE PINES	17842 NW 2nd Street, Pembroke Pines, FL 33029	Ph: 954-430-9901	Fax: 954-432-343(
PLANTATION	220 S.W. 84th Avenue, Suite 102, Plantation, FL 33324	Ph: 954-720-1530	Fax: 954-720-6540

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Skin Surgery

Toenail Surgery

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Nerve Injuries
- Neuromas
- Tarsal Tunnel
- Entrapments

COMPANY POLICIES

PLEASE READ THE EXPLANATION OF OUR COMPANY POLICIES AND SIGN BELOW.

INSURANCE BENEFITS:

IT IS IMPERATIVE THAT YOU KNOW AND UNDERSTAND YOUR INSURANCE BENEFITS PRIOR TO YOUR APPOINTMENT. PLEASE TAKE A MOMENT TO CONTACT YOUR INSURANCE COMPANY FOR AN EXPLANATION OF BENEFITS REGARDING CO-PAYS, DEDUCTIBLES, REFERRAL REQUIREMENTS, AUTHORIZATION REQUIREMENTS, COST FOR DURABLE MEDICAL EQUIPMENT SUCH AS BRACES, ETC. PLEASE UNDERDTAND THAT IT IS YOUR RESPONSIBILTY TO KNOW YOUR INSURANCE COVERAGE.

INITIAL HERE:_____

MEDICAL RECORDS REQUEST:

MEDICAL RECORDS REQUESTS NEED TO BE MADE IN ADVANCE. IT WILL TAKE APPROXIMATELY 7-10 BUSINESS DAYS TO COMPLETE DICTATIONS, SO PLEASE BE PATIENT. THERE IS NO CHARGE FOR PAPER COPIES OF MEDICAL RECORDS.

INITIAL HERE:_____

X-RAY COPIES:

REQUEST FOR X-RAY COPIES NEED TO BE MADE IN ADVANCE. IT CAN TAKE APPROXIMATELY 3-7 BUSINESS DAYS FOR THE COPIES TO ARRIVE, AS THEY ARE NOT MADE IN THE OFFICE. THER IS A $15 FEE PER X-RAY FILM THAT WILL NEED TO BE COLLECTED PRIOR TO MAKING THE COPIES. WE WILL NOT MAKE THE COPIES UNLESS PAID IN ADVANCE.

INITIAL HERE:_____

CO-PAYMENTS: (IF APPLICABLE)

CO-PAYS WILL BE COLLECTED WHEN YOU ARRIVE FOR YOUR APPOINTMENT. PLEASE UNDERSTAND THAT YOU WILL HAVE A CO-PAY (IF APPLICABLE) FOR EVERY OFFICE VISIT, I.E MRI FOLLOW-UPS, CAST CHECKS ETC.

INITIAL HERE:_____

BY SIGNING I CONFIRM THAT I HAVE READ AND UNDERSTAND THE COMPANY POLICIES.

_____

PRINTED NAME

_____ _____

SIGNATURE **DATE**

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