Marin Foot and Ankle Center, PA

Specializing in Trauma & Reconstructive Surgery of the Foot, Ankle, & Leg

3410 W 84 St Suite# 100. Hialeah, FL 33018 * Phone: (305) 826-7774 / Fax: (305)-826-5505

Patient Demographic and Insurance Intake Form

Last Name (Apellido): _____ First name (Primer Nombre): _____

DOB (Fecha De Nacimiento):_____ SS #: _____ Sex: _____ Marital Status:_____

Address (Direcion):_____

City (Ciudad): _____ State (Estado): _____ Zip Code (Codigo postal): _____

Home Phone (Numero de casa) : _____ Cell Phone (Numero de Cellular): _____

E-mail (Correo electronico): _____@_____

Referred by (Referido Por): _____

Primary Care Physician Name (Nombre de su Doctor Primario):_____

PCP ph#:_____ Pharmacy ph# (Numero telefono de farmacia):_____

Insurance Information

Primary Insurance Co (Nombre de Seguro): _____

ID #:_____ Grp#:_____

Medical History

Diabetic (Diabetic)? Yes or No

Astham (Asma)?_____ Hypertencion (Presion alta) ?____ Cancer? ____ Kidney Disease (Problema en riñones)?____

Infectious diseases? (hepatitis, T.B., AIDS, Lyme)_____ Major Surgery (Cirugias)?_____

Are you allergic to any medications (Allergias)? (if so, please list)

_____

_____

_____

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HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

□ Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
□ Obtain payment from third party payers.
□ Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations Privacy officer to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.
Patient Name (printed):
Signature (Firma): _____ Date (Fecha): _____

Consent for Evaluation and/or Treatment

By signing below, I am giving my consent to the practice of Marin Foot and Ankle Center for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline.
Patient Name (printed):
Signature (Firma): _____ Date (Fecha) : _____