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

❒ Robert H. Sheinberg, D.P.M., Foot & Ankle Surgeon	❒ 1600 Town Center Blvd., Weston, FL 33326	(954) 389-5900
❒ Augustine A. Bollo, D.P.M., Foot & Ankle Surgeon	❒ 17842 N.W. Second St., P. Pines, FL 33029	(954) 430-9901
❒ Mark Beylin, D.P.M., Foot & Ankle Surgeon	❒ 140-A S.W. 84 Ave., Plantation, FL 33324	(954) 916-0550
❒ Iliya Beylin, D.P.M., Foot & Ankle Surgeon	❒ 7447 N. University Dr., Tamarac, FL 33321	(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 ______________ City ______________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________ E-Mail ______________

Driver's License # ______________ Driver's License State ______________

DOB ______________ Age ______ Sex ______ SS No. ______________ Occup. ______________

Employer/School ______________ Business Phone ______________

Address ______________ City ______________ State ______ Zip ______

Permanent Resident Yes No If no, Please list 2nd address.

Address ______________ 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 ______________

Address ______________ City ______________ State ______ Zip ______

Phone ______________ ______________

PRIMARY INSURANCE

Name of Company ______________ Phone ______________

Address ______________ City ______________ State ______ Zip ______

ID# ______________ Group No. ______________

Insured's Full Name ______________ Is this an Employer's Plan? Yes No

Insured Soc. Sec. No. ______________ Insured D.O.B. ______________

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

SECONDARY INSURANCE

Name of Company ______________ Phone ______________

Address ______________ City ______________ State ______ Zip ______

ID# ______________ Group No. ______________

Insured's Full Name ______________ Is this an Employer's Plan? Yes No

Insured Soc. Sec. No. ______________ Insured D.O.B. ______________

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.

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