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
☐ Nathan D. Vela, D.P.M., Foot & Ankle Surgeon
☐ Michael M. Cohen, 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

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 Phone _____E-Mail_____

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: Name of Company _____ Phone _____

Address _____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)_____

SECONDARY INSURANCE: Name of Company _____ Phone_____

Address _____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?_____
□ Bell South □ City Limits □ Our City Weston □ Salud al Dia □ Parklander
□ Weston Lifestyle □ Estate Lifestyle □ Weston Express □ Hospital □ Insurance Company
□ Sport and Activities □ Pines/Miramar Advisor □ Davie and the Ranches □ Parkland Lifestyle □ Expressions
□ Doctor's Name_____ □ Patient Name_____ □ Other_____

MEDICAL: (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
□Human Immunodeficiency Virus (HIF) □ Other: _____

ALLERGIES:

☐ Penicillin ☐Aspirin ☐ Codeine ☐ Novocain ☐ 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 diskogenic 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)

Please complete for Worker's Compensation Injury	
Describe Injury:	Type of Job:
How did accident happen?	Date of Accident:
FOR WORKER'S COMPENSATION INJURIES ONLY. You must report your injury to your employer and he must then report it to his insurance carrier. If we do not receive Worker's Compensation forms to fill out within 60 days, you will be billed and held responsible for payment.	