Patient Information Sheet

Date: ___ /___ /___

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SS#: _____ –_____ –_____ Age: _____

Weight: _____ Height: _____ Shoe Size: _____
Emergency Contact: _____

Phone Number: _____ Relationship: _____

Reason For Today's Visit: _____

_____

Primary Care Physician: _____ Phone: _____

Date Last Seen: ___ /___ /___

Please List Any Allergies: _____

_____

Current Medications: _____

Medical Conditions: _____

Please Check All That Apply

( ) Heart Disease	( ) Arthritis	( ) Thyroid Condition
( ) Epilepsy	( ) Hypertension	( ) Blood Disorders
( ) Diabetes	( ) Liver Disease	
( ) Lung/Respiratory Problem		

If other please list: _____

Past Surgeries: _____

_____

_____

Is Your Injury Accident Related? ( ) Yes ( ) No

Whom may we thank for referring you to us? _____

Insurance Information:

Company: _____ Policy/ID #: _____

Group #: _____ Policy Holder's Name: _____

( ) **I have NO insurance**

I will be paying today by: ( ) Cash ( ) Check ( ) Credit Card

I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for any services rendered.

I have read this form in its entirety, and answered the questions to the best of my knowledge. I certify that the information provided is true and correct. I understand that it is my responsibility to notify this office of any charges in my status or above information.

Signature: _____ **Date:** _____

Dr. Daniel S. Brandwein, DPM, FACFAS

MULTI CONSENT FORM

PATIENT CONSENT TO X-RAYS

I, _____, authorize the performance of diagnostic X-ray Examination of myself, which the above doctor or his associates may consider necessary or advisable in the course of my examination and treatment;

Signed: _____ Date: _____

NON-PREGNANCY VERIFICATION

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform diagnostic X-ray examination. I have been advised that X rays can be hazardous to an unborn child.

Date of last menstrual period: ___ / ___ / ___

Signed: _____ Date: _____

CONSENT TO TREAT/X-RAY A MINOR

I, _____, authorize the performance of diagnostic X-ray Examination and/or treatment of my child or ward, _____ which the above doctor or associates may consider necessary or advisable in the course of examination and treatment. The patient is a minor, ___ years of age.

Signed: _____ 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 them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name: _____ Date: _____

Parent, Guardian, or Legal Representative: _____

Signature: _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Notice of Information Practices and Privacy Statement

How We Collect Information About You: Dr. Daniel Brandwein Podiatry and Surgery(DBPS), and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between DBPS and health care providers, medical product or service providers, pharmacies, Insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the Intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.drdanbrandwein.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of DBPS. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Dr. Daniel Brandwein Podiatry and Surgery

159 South Pompano Pkwy, Pompano Beach, FL 33069 (954)984-7500 Feetdoc@aol.com

For Office Use Only

Date: ___ /___ /___

Patient's Name: _____ Date of Birth: _____

Insurance Company: _____

Telephone #: _____ Fax #: _____

Policy #: _____ Group #: _____

Member ID #: _____

Ded: _____ Been Met: _____ Not Been Met: _____

X-rays: _____% Orthotics : _____% Therapy: _____%

Address Claims Sent To:

_____

City: _____ State: _____ Zip Code: _____

Spoke With: _____ Ext: _____

Taken By: _____

Notes Information

Patient Name: _____