Name: _____ Phone: _____ Cellular:

Address: _____ City: _____ State: _____ Zip:

Age: _____ Birthdate: _____ Sex: ____ SSN _____

Employer's Name: _____

Employer's Address: _____

Employer's Phone:

Your Ins. Co: _____ Policy #: _____ Agent:

Name on Policy (if other than self): _____ Policy # _____

Do you own a car?

Do you have insurance?

NATURE OF ACCIDENT

1. Date of Accident: _____
2. Make of vehicle: Year:
3. Were you ( ) Driver ( ) Front Seat Passenger ( ) Back Seat Passenger
4. Number of people in your vehicle? _____ Were you wearing seat belts? ( ) Yes ( ) No
5. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
6. What direction was other vehicle headed? ( ) North ( ) South ( ) East ( ) West
7. Were you struck from : ( ) Behind ( ) Front ( ) Left side ( ) Right side
8. Approximate speed of your car _____ mph other car _____ mph
9. Were you knocked unconscious ? ( ) Yes ( ) No If yes, for how long? _____
10. At the time of impact, were you looking: ? ( ) Straight ( ) Left ( ) Right ( ) Back
11. Both hands on the steering wheel? ( ) Yes ( ) No
12. Was your foot on the brake? ( ) Yes ( ) No

13. Did you strike anything in car at the time of impact ( ) Yes ( ) No

    Steering wheel Dashboard Windshield Door Window Other _____

    State Part of Body:
    Chest Chin Knee Shoulder Hand Head Other _____

14. Any lacerations (cuts) or bruises> ( ) Yes ( ) No

15. Were you dazed? ( ) Yes ( ) No

16. Were police notified? ( ) Yes ( ) No

17. In your own words, please describe the accident:

    _____

    _____

18. Did you have any physical complaints **BEFORE THE ACCIDENT**? ( ) Yes ( ) No If Yes, describe:

    _____

    _____

19. What are your present complains and symptoms?

    _____

    _____

20. Do you have any previous illnesses which relate to this case? ( )YES ( ) NO
    If yes, please describe:

    _____

    _____

21. Have you ever been involved in an accident before? ( )YES ( ) NO
    If yes, please describe include date(s) and type(s) of accidents and injuries received:

    _____

    _____

22. Have you been treated by another doctor since the accident? ( )YES ( ) NO

23. Since this injury occurred, are your symptoms:

( )Improving ( ) Getting Worse ( ) Same

24. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Review of Systems

___ Headache
___ Neck pain
___ Stiff neck
___ Sleeping problems
___ Back pain
___ Nervousness
___ Tension
___ Irritability
___ Chest pain
___ Visual Disturbances
___ Weight Loss
___ High blood pressure
___ Blood in stool
___ Blood in urine
___ Bleeding
___ Cough
___ Swelling
___ Heat/Cold intolerance
___ Heartburn
___ Dizziness
___ Head seems too heavy
___ Pins & needles in arms
___ Pins & needles in legs
___ Numbness in fingers
___ Numbness in toes
___ Shortness of breath
___ Fatigue
___ Palpitations
___ Rashes
___ Upset Stomach
___ Nausea/vomiting
___ Chills
___ Fever
___ Wheezing
___ Incontinence
___ Transfusions
___ Depression
___ Fainting
___ Loss of memory
___ Loss of balance
___ Loss of smell
___ Loss of taste
___ Ringing in ears
___ Easy bruising
___ Enlarged glands

Symptoms other than above:

_____

Have you ever had this condition/problem before ( )YES ( ) NO

25. PAIN LEVEL: On a scale of 0-10, with 0 being you're pain free and can function quite well, and 10 being you're in excruciating pain all the time, where would you rate the intensity of pain?

0 1 2 3 4 5 6 7 8 9 10

No pain Low pain Moderate Pain Intense Pain Excruciating pain

Patient Name: _____

26. Have you lost time from work as a result of this accident? ( )YES ( ) NO If YES, please complete:

Last day of work: _____

Type of employment: _____

Are you compensated for lost time at work? ( )YES ( ) NO

If YES, please detail how: _____

27. Do you notice any activity restrictions as a result of this injury? ( )YES ( ) NO If YES, please explain: _____

28. Other patient information _____

HOSPITAL INFORMATION:

1. Did you go to the hospital? ( )YES ( ) NO
2. When did you go? _____
3. How did you get to the hospital? ( )Ambulance ( ) Private Transportation
4. Name of Hospital? _____
5. Were you x-rayed? ( )YES ( ) NO
6. Did you receive any medication? ( )YES ( ) NO

PASSENGER INFORMATION ONLY:

1. Do you own a car? ( )YES ( ) NO
2. If no, does anyone in your house own a car? ( )YES ( ) NO
3. If yes, please provide the information below :

   Name: _____

   Address: _____

   Insurance Co: _____

   Policy Number: _____

Signature _____ Date _____

Dr. Daniel Brandwein, D.P.M., F.A.C.F.A.S
159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

Weight: _____ Height: _____ Shoe Size: _____

Emergency Contact: _____
Relationship: _____
Email address: _____

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: _____

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily, and intentionally assign the rights and benefits of my automobile insurance, also known as personal injury protection (Here after PIP), and medical payments policy of insurance to the above healthcare provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payments at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for a payment and if the provider's bills are paid or applied to a Deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes transportation over do you interest and any potential claim for common law or attorney bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this documents. Failure to inform the provider shall results in a waiver by the insurer to contest the validity of this document. The undersigned directs the insured to pay the health care provider directly without including the patients name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlements of a claim that contain or are accompanied by language releasing the insurer or it's insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (here in after EUO) the insurer is hereby instructed to send a copy of side notification to this provider. The provider or the providers attorney is expressly authorized to appear at any EEO or I am he sat by the insurer the healthcare provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and to valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, copayments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The healthcare provider is given the power of attorney two: endorse my name on any checks for services rendered by the above provider, and to request and obtain a copy of any statements of examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish and ensure, and ensures intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records to obtain insurance coverage information in writing (declaration sheets) and telephonically from the insurer, request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer, obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, x-rays, IMEs, and MRIs From any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and conditional and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: demand is hereby made for the insurance to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage deduction sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. however, it's a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. it's a bill from this provider and claim from anyone else is received by the insurance on the same day than the insurer is directed to pay this provider first before the policy is exhausted. In the event the providers medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is two: set aside the entire amount disputed or reduced; escrow the full amount at issue; And not pay the disputed amount to anyone or any Anthony, including myself, until the dispute is resolved by a quarts. Do not exhaust the policy. The insurer is instructed to inform, and writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been promised anything in exchange for receiving healthcare; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the providers prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name: _____ Patient's Signature: _____

(Please print) (If patient is a minor, signature of parent/guardian)

Date: _____

Dr. Daniel Brandwein, D.P.M., F.A.C.F.A.S
159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

TO: _____ RE: _____

_____ DOB: _____

_____

_____

DOL: _____

I do hereby authorize the office of Dr. Daniel Brandwein, to furnish you, my attorney, with, a full such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any and all other bills that are due his office and to withhold such suns from any settlement, judgment, or verdict as may be necessary to adequately protect and full compensate this office of Dr. Daniel Brandwein. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of injuries for which I have been treated, in connection therewith.

I fully understand that I am directly and fully responsible to the office of Dr. Daniel Brandwein for all medical bills submitted by his office for services rendered me and that this agreement is made solely for the office of Dr. Daniel Brandwein's additional protection, and in consideration for this awaiting payment. I further understand that such payment is not contingent in any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify the office of Dr. Daniel Brandwein of any changes or addition of attorney(s) used by lien connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the Doctors office. I have been advised that if my attorney does not wish to cooperate in protecting the office of Dr. Daniel Brandwein's interest, his office will not await payment but may declare the entire balance due and payable. I further direct my attorney to pay the office of Dr. Daniel Brandwein one hundred percent of all costs associated with my treatment. I understand all costs associated with my dare and believe them to be necessary, reasonable and customary report of his examination, diagnosis, treatment, prognosis, etc..., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney to pay directly to the office of Dr. Daniel Brandwein.

Dated: _____ _____

Patient Signature

The undersigned being the attorney of record for the above Patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and full compensate the office of Dr. Daniel Brandwein. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees, costs and interest at the applicable legal interest rate.

Dated: _____ _____

Attorney Signature

PLEASE DATE, SIGN AND RETURN ONE COPY TO DOCTOR'S OFFICE, ALSO KEEP ONE FOR YOUR RECORDS.

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: _____

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

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.

Dr. Daniel Brandwein, D.P.M., F.A.C.F.A.S
159. S Pompano Parkway
Pompano Beach, Fl 33069
Phone (954) 984-7500 Fax (954) 984-8884

Patient: _____

Date: _____

RECORDS/X-RAY RELEASE:

I, _____, have requested the release of records/ x-rays which are part of my permanent records at the above stated clinic.

I hereby acknowledge receipt of these records/radiographs in consideration of the foregoing:

I hereby release and forever discharge the aforesaid clinic/doctor from any and all responsibility and liability of any type, nature or character, whatsoever arising from said records.

The transaction is consummated at my specific request.

_____

Signature

_____

Witness

159. S Pompano Parkway
Pompano Beach, Fl 33069
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Attorney Information Sheet

Patient Name: _____ DOA: _____

Have you consulted with an Attorney for this case? ( ) YES ( ) NO

If yes, please provide us with the following:

Attorney name: _____

Attorney Address: _____

_____

_____

Attorney Phone: (_____) _____ - _____ Attorney Fax: (_____) _____ - _____

Do you have your Attorney's business card? ? ( ) YES ( ) NO

If yes, please provide us with one.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Office Use Only

Office Contact: _____

LOP Sent: ( ) YES ( ) NO To Fax # : (_____) _____ - _____

LOP Received: ( ) YES ( ) NO Reason: _____

Primary Insurance: _____

Total Billing: $_____ Total Payments: $_____ Final Bill $_____

Secondary Insurance: _____

Total Billing: $_____ Total Payments: $_____ Final Bill $_____

Settlement Received: $_____

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: _____