SEGALL FOOT & ANKLE, INC.
SOUTH FLORIDA ORTHOPEDIC GROUP
ARTHUR SEGALL, JR., DPM, FACFAS
Plantation: 201 NW 82nd Ave, Suite 102, Plantation, Florida 33324
Ft. Lauderdale: 4800 NE 20th Terr, Suite 303, Ft. Lauderdale, Florida 33308
Margate: 2825 State Road 7, Suite 204, Margate, Florida, 33063 Phone:
Web: anklefocus.com Phone: (954) 384-2555 Fax: (954) 900-5646 **Email**: advfoot@bellsouth.net

Please Print & Answer All Questions

Today's Date: _____ (Office Use Only) Chart Number: _____

Patient Name: _____ **Date of Birth:** _____ **Age:**_____

Address:_____ **City** _____ **State**: _____ Zip _____

Cell Phone: _____ **Secondary Number:** _____

Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Separated

Gender at Birth: [ ]Male [ ]Female

Gender Identity If Applicable: [ ]Transgender Female [ ]Transgender Male [ ]Gender Variant [ ]Other

Race: [ ]Caucasian [ ]African American [ ]Hispanic [ ]American Indian [ ]Hawaiian Pacific [ ]Asian Ethnicity

Email Address: _____ **Languages Spoken:** _____

Occupation: _____ **Employer** _____

Emergency Contact Name: _____ **Relation:** _____ **Cell Phone:** _____

Insurance Company Name: _____

Responsible Party's Name If Different From Patient:_____

Date of Birth_____ **Relationship to Patient** _____

Who Referred You To Us? : _____

Primary Medical Doctor Name/Address/Phone/Fax: _____

_____

Please Send A Copy Of My Report To My Doctor: [ ] Yes [ ] No

Pharmacy Name:_____ **Address:** _____

Phone:_____ **Fax:**_____

Medical Information: **Height:** _____ **Weight:** _____

Location of Problem [ ] Left [ ] Right [ ] Toe(s) [ ]Foot [ ] Heel [ ] Ankle [ ] Leg

Date of Accident/Injury/Onset: _____ **Previous Treatment:** [ ] Yes [ ] No

If Yes, When? _____ **Doctor's Name:** _____ **Hospital/Clinic:** _____

What Type of Treatment? Physical Therapy _____ Medications _____ Casts/Braces _____ Injections _____

Types of Pain: Aching [ ] Yes [ ] No Tingling [ ] Yes [ ] No Numbness [ ] Yes [ ] No

Radiating/Shooting [ ] Yes [ ] No Sharp/Stabbing [ ] Yes [ ] No

Additional Tests: X-Rays MRI CT Scan Bone Scan Ultrasound EMG/NCS Other _____

History Of Similar Problems? [ ] Yes [ ] No, If Yes, Please List Treating Doctor and Treatment:

_____

If Motor Vehicle Accident: Driver _____ Passenger _____ Seat Belt [ ] Yes [ ] No Airbags [ ] Yes [ ] No

Car Was Hit: Front End: _____ Rear End: _____ Driver Side: _____ Passenger Side: _____

Patient Name: _____ **Today's Date:** _____

ALLERGIES To Medications or Dyes: _____

MEDICATIONS Taken Daily or Periodically: _____

_____

_____

DO YOU HAVE NOW OR HAVE YOU HAD IN THE PAST ANY OF THE FOLLOWING PROBLEMS?
If YES To Any Of The Questions Below, Please Briefly Explain. For Example: Cancer: Breast/Skin, Lung Problems: Asthma, Blood Disorders: Anemia, Liver Problems: Hepatitis etc.

Arthritis _____	[ ] Yes	[ ] No	Lung Problems_____	[ ] Yes	[ ] No
Blood Disorders_____	[ ] Yes	[ ] No	Mental Health_____	[ ] Yes	[ ] No
Cancer _____	[ ] Yes	[ ] No	Neurological Diseases_____	[ ] Yes	[ ] No
Diabetes, Year Diagnosed_____ Sugar Levels AM:_____ PM:_____	[ ] Yes	[ ] No	Prostate Conditions_____	[ ] Yes	[ ] No
Elevated/High Cholesterol _____	[ ] Yes	[ ] No	Skin Disorders_____	[ ] Yes	[ ] No
Heart Disease _____	[ ] Yes	[ ] No	STD's_____	[ ] Yes	[ ] No
Hypertension _____	[ ] Yes	[ ] No	Stomach/Ulcer Problems _____	[ ] Yes	[ ] No
Urinary/Kidney Problems_____	[ ] Yes	[ ] No	Thyroid Problems _____	[ ] Yes	[ ] No
Liver Problems _____	[ ] Yes	[ ] No	Vascular/Circulation Problems_____	[ ] Yes	[ ] No
Any Other_____	___	__	_____	[ ] Yes	[ ] No

FAMILY HISTORY (Family Members With Any Of The Above Problems: Grandparents, Mother, Father, Brother, Sister etc) If yes, which problems and who:

_____

_____

PAST SURGERIES? [ ] Yes [ ] No, If Yes, Please List: _____

_____

Have You Been HOSPITALIZED FOR ANY OTHER PROBLEMS? [ ] Yes [ ] No

If Yes, Please Describe Condition: _____

TETANUS SHOT With In The Past 10 Years? [ ] Yes [ ] No When? _____

Can You Take ASPIRIN? [ ] Yes [ ] No

Right Handed [ ] **Left Handed** [ ]

COULD YOU BE PREGNANT? [ ] Yes [ ] No

Do You SMOKE? [ ] No [ ] Yes ---- If Yes, How Much? _____ Pack(s)/Cigarettes/Cigars Per Day

Do You Drink ALCOHOL? [ ] No [ ] Yes --- If Yes, How Much?_____

Do You Have A History Of DRUG OR SUBSTANCE ABUSE? [ ] No [ ] Yes --- If Yes, List_____

PATIENT OR GUARDIAN SIGNATURE: _____

Consent to Medical Care

I understand that I have a medical condition that requires medical treatment. I authorize the physicians at Segall Foot & Ankle, Inc./South Florida Orthopedic Group to determine what kind(s) of treatment and/or diagnostic procedures (tests) must be done in order to treat/learn more about my condition. These may include, but not limited to x-rays, diagnostic tests, MRIs, CT Scans, Bone Scans and/or other routine tests, and/or physical therapy. I understand that if my doctor advises a more complex test or tests with special risks that it will be explained to me. Further, I authorize the personnel of Segall Foot & Ankle, Inc./South Florida Orthopedic Group to give, or assist in giving, the tests/therapy/treatments that the physicians may order. I fully understand that medical tests/physical therapy/treatments may involve certain unavoidable risks.

I also authorize the physicians at Segall Foot & Ankle, Inc./South Florida Orthopedic Group to determine what kind of treatment is to be given and to perform such procedures as they may deem necessary in their professional judgment to preserve my health.
I understand that the practice of medicine and surgery are not exact sciences and acknowledge that no guarantee or assurance has been made to me as a result of treatments and examinations.

Assignment of Benefits & Financial Responsibility

I hereby authorize and direct my insurance carrier(s) and/or any other health/medical plan to issue payment directly to Segall Foot & Ankle, Inc./South Florida Orthopedic Group for all medical and surgical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for all medical/surgical charges, whether or not paid by my insurance company, and I will be responsible for paying any outstanding balances from services rendered by Segall Foot and Ankle, Inc that are not paid by my insurance company and/or attorney lien. If my account is referred to an agency or attorney for collection, I understand that I will be responsible for all collection cost, attorney fees, court cost, and any outstanding balances for service rendered.

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting South Florida Orthopedic Group at (954) 771-8177.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

Consent for Transfer of Biological Specimen

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Segall Foot & Ankle, Inc/South Florida Orthopedic Group, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then betransferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Segall Foot & Ankle, Inc/South Florida Orthopedic Group to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature Patient/Guardian: _____ **Date:** _____

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Web: footandanklefocus.com **Email**: advfoot@bellsouth.net

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information, copy of my medical records, summary or narrative of my protected health information, to the physician listed below.

Patient Name: _____

Date of Birth: _____

The information you may release subject to this signed release form is as follows:

[ ] Complete Records	[ ] History & Physical	[ ] Progress Notes
[ ] Care Plan	[ ] Lab Reports	[ ] Radiology Reports
[ ] Pathology Reports	[ ] Treatment Record	[ ] Operative Reports
[ ] Hospital Reports	[ ] Medication Record	[ ] Other

From: _____ Fax #: _____

Release my protected health information to the physician listed below:

ARTHUR SEGALL, JR., DPM, FACFAS
201 NW 82nd AVENUE, SUITE 102
PLANTATION, FLORIDA 33324
Phone: (954) 384-2555
Fax: (954) 900 -5646

The records requested are to assist with ongoing treatment.

Signature of Patient/Guardian:_____

Printed Name: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):_____