Dr. Jay R. Newman **Dr. Laura M. Newman** **Dr. Patricia Bedoya**

PATIENT INFORMATION FORM (PRINT ONLY PLEASE)

Name: _____ _____ _____ Date:_____/_____/_____
(First) (Initial) (Last)

Local Address: _____

City _____ State_____ Zip Code_____

Home Phone #: (_____) _____-_____Cell Phone #:(_____)_____-_____

Date of Birth: _____ Social Security #: _____ Email:_____

Emergency Contact/Relation: _____Phone #: (_____)_____-_____

Primary Insurance: _____ Secondary Insurance: _____

Primary Doctor: _____ PCP Phone #: (_____)_____-_____
Last visit to Primary Care Doctor: _____
Pharmacy (Name/City): _____ Phone #: (_____)_____-_____

Who referred you to our office? _____ Shoe size ( ) Height_____ Weight_____

SURGICAL HISTORY _____

Pacemaker/Defibrillator ___YES ___NO Bypass Surgery/Vascular Surgery/Stent ___YES ___NO

Joint Replacement: HIP KNEE SHOULDER ANKLE OTHER: _____

Chemo/Radiation: YES (CURRENTLY) / YES (IN THE PAST) / NO If yes, list cancer type:_____

List FOOT PROBLEMS: _____How long (circle): days / months / years

MEDICAL HISTORY (Check YES or NO):

Diabetes ___Yes ___No (TYPE 1 OR 2) Anemia ___Yes___ No Hypertension ____Yes ___No Murmur __Yes __No

Heart Ailment ___Yes ___No Hepatitis ___Yes ___No Mitral Valve Prolapse ___Yes ___NO

Blood Condition; (Phlebitis, Clotting, Disorder, Gout) _OTHER:_____

LIST ALLERGIES: _____Allergic to Eggs or Baker's Yeast? __YES ___NO

List Current MEDICATIONS
1._____ 2._____
3._____ 4._____
5._____ 6._____

Tobacco Use: ___Yes ___No # Packs per day _____ Years: _____ Quit Date:_____
Alcohol Use: ___ Yes ___ No Rarely_____Moderately_____Daily_____Occasional_____Quit_____

I, the undersigned certify that I have insurance coverage with the above listed insurance, and assign to Newman & Bedoya Podiatry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I AUTHORIZE THE USE OF THE SIGNATURE LISTED BELOW ON ALL INSURANCE SUBMISSIONS.

Patient Signature _____ Date: _____

SIGN BACK OF PAGE

FOOT & ANKLE MEDICINE & SURGERY

DR. JAY R. NEWMAN DR. PATRICIA BEDOYA DR. LAURA NEWMAN

15340 JOG RD, STE 205, DELRAY BEACH, FL 33446 Phone (561-638-7600) Fax (561-600-4104)
6080 BOYNTON BEACH BLVD, STE 220, BOYNTON BEACH, FL 33437 Phone (561-369-4455) Fax (561-369-4483)

PRIVACY AND CONSENT INFORMATION

This consent form is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which requires us, by law to inform you of your rights for privacy with respect to the disclosure of your health care information.
(Please read and sign below)

I hereby give my consent to Dr. Jay R. Newman, PA to use and disclose my protected health information for the purpose of treatment,payment and operations of my health care and this practice.

Consent for treatment: I authorize Jay R.Newman, PA and any employee working under the direction of my physician to provide medical care for me or the patient, which I am legally responsible for. This medical care may include services and supplies related to my health (or the identified person) and may include (but not be limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical and mental status/function of the body and the sale or dispensing of drugs, devices, or other items required in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for the Release of Information for Payment and Operations: I also authorize Dr. Jay R. Newman, PA to furnish information to the identified insurance carrier(s) for any and all payments activities. I further consent to the use for any practice operational needs as identified in the **Privacy Practice Notice.**

Consent Related to the Privacy Notice: I have had an opportunity to review the **Privacy Practice Notice** as part of this registration process. I understand that the terms of the Privacy Practice Notice may change and I may obtain these revised notices at any time by
contacting them by phone, fax, email, or in writing. I have the right to request information on how my protected health information has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at this time as well. If it does agree to abide by my requested restrictions, then this practice is bound by that agreement. All requests for disclosure and/or restriction must be made in writing for documentation purposes.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at this time as well. If I revoke this consent, the revocation does not go into effect until this practice receives documented notification (i.e. in writing)

Patient/Guardian: _____ Date:_____
(Please sign here)
Name (Printed): _____ Relationship: _____
Copy of Practice Privacy Policy reviewed and sign on**: _____**

Patient unable to sign privacy statement due to: _____

Consent for Assignment of Benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applicable to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I further understand that my contract with my ins entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are ensued.

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