Dr. Harold Cesar, DPM
Medicine and Surgery of the Foot & Ankle
PODIATRY ASSOCIATES OF FLORIDA

Phone: (904) 778-3000
Fax: (904) 771-2002
www.jaxfootandankle.com

NEW PATIENT INFORMATION

FIRST NAME:	**MIDDLE NAME:**	**LAST NAME:**
Date Of Birth:	Gender: ☐ Female ☐ Male	SSN:
Address:		
City:	State:	ZIP:
CELL PHONE #:	**HOME PHONE #:**	**EMAIL:**

We are required to ask the following questions, however, you may choose not to answer:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White ☐ American Indian / Alaska Native ☐ Hispanic or Latino ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other/Decline

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Other/Decline

IF PATIENT IS A MINOR - PARENT INFORMATION:

First Name:	Last Name:
Date of Birth:	SSN:

REASON FOR TODAY'S VISIT:

_____

_____

HOW DID YOU HEAR ABOUT US?

☐ Insurance, ☐Internet/Web, ☐Physician: _____, ☐Family/Friend, ☐Other: _____

Check if you have seen any of our other providers within last 3 years:

☐Dr. Bleau, ☐Dr. Efron, ☐Dr. Herbst, ☐Dr. Lagoutaris, ☐Dr. Matey, ☐Dr. Tillo, ☐Dr. Yant

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY #1:		**INSURANCE COMPANY #2:**	
Policy Holder Name:		Policy Holder Name:	
Member ID:	Effective Date:	Member ID:	Effective Date:
Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
Policy Holder's Social Security #:		Policy Holder's Social Security #:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent		Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent	
Is Referral Required? ☐ Yes ☐ No		Is Referral Required? ☐ Yes ☐ No	

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YOUR NAME: _____ DOB: _____ TODAY'S DATE: _____

SURGICAL HISTORY (List all your surgeries in the past 5 years)

1.	Year:
2.	Year:
3.	Year:
4.	Year
5.	Year:

PAST MEDICAL HISTORY (Check any of the following if you still have, or have ever had)

☐ AIDS/HIV	☐ Epilepsy	☐ Kidney Problems	☐ Psychiatric Care
☐ Anemia	☐ Fainting	☐ Liver Problems	☐ Rheumatoid Arthritis
☐ Arthritis	☐ GERD	☐ Lung Disease	☐ Seizures
☐ Asthma	☐ Gout	☐ Melanoma	☐ Swelling Ankle/Feet
☐ Bleeding Tendencies	☐ Headaches	☐ Neuropathy	☐ Stomach Ulcers
☐ Cancer	☐ Heart Disease	☐ Osteoporosis	☐ Stroke
☐ Chest Pain	☐ Hemophilia	☐ Pneumonia	☐ Tuberculosis (TB)
☐ Circulatory Problem	☐ Hepatitis	☐ Problems with Anesthesia	☐ Varicose Veins
☐ Diabetes	☐ High Blood Pressure	☐ Psoriasis	☐ Venereal Disease

Can You Take Aleve/Advil/Aspirin Without Problems?
☐ Yes ☐ No

Women – Are You Pregnant Or Possibly Pregnant?
☐ Yes ☐ No

Are you Diabetic? ☐ Yes ☐ No

If Yes, Who Is Your Supervising Provider? (PCP or Endocrinologist)

_____

Date Of Last PCP/ENDO Appointment: _____

CURRENT MEDICATIONS (☐ no medications / ☐ list attached)

1.
2.
3.
4.

ANY KNOWN ALLERGIES (☐ no known allergies)

1.
2.
3.
4.

YOUR SOCIAL HISTORY

Do You Use Tobacco? ☐ Yes ☐ No	Do You Use Alcohol? ☐ Yes ☐ No

YOUR FAMILY HISTORY (Please Indicate **M** for Maternal, **P** for Paternal, or **S** for Sibling)

☐Cancer	☐Gout	☐Heart Disease	☐Sickle Cell Disease
☐Diabetes	☐Heart Attack	☐High Blood Pressure	☐Stroke

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YOUR NAME:_____ DOB:_____ TODAY'S DATE:_____

PATIENT CONTACTS

YOUR PRIMARY CARE PROVIDER (PCP):	PCP Phone #:
PCP Address:	
PHARMACY:	Pharmacy Phone #:
Pharmacy Address/Location:	
EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone #:	
PLACE OF EMPLOYMENT:	Employer Phone #:
What Type of Work Do You Do?	

YOUR HEIGHT:_____ YOUR WEIGHT:_____ YOUR SHOE SIZE:_____

PAYMENTS: CoPays are due at time of service (which includes Medicare patients). Selfpay patients are required to pay in full at time of service. Your medical claim will be forwarded to your secondary insurance (if any) after payment is received from your primary insurance. You are required to follow the guidelines of your managed care plan. You must have a referral from your primary if your plan requires one. If one is not provided, you can be held financially responsible for service. You will be sent up to three notices for your financial responsibility after payment is received from your insurance company. After the third notice, your account will be forwarded to collections. An additional $25.00 will be added to your account for all returned checks. You are to inform the doctor's office if there are any changes in your health insurance information. You agree to pay Podiatry Associates of Florida for any remaining balance after insurance payment has been made.

AUTHORIZATION AND ASSIGNMENT: For The Services Rendered And Those About To Be Rendered, I Hereby Assign To **P**odiatry **A**ssociates **o**f **F**lorida (hereinafter referred to as "PAOF"} All Medical And/Or Surgical Benefits Otherwise Payable To Me Under The Above Described Policy Not To Exceed The Charges Made For Such Services. I Further Direct That They Make No Payments To Me. In The Event That I Receive Payment From The Insurance Company I Agree To Endorse Such Payment To **PAOF** Immediately. I Understand That I Am Directly And Primarily Responsible To **PAOF** For their Usual And Customary Fee For The Services Rendered To Me. I Realize That If My Insurance Company Fails To Pay Or If There Is A Delay (More Than 75 Days) In Their Paying It Is My Sole Responsibility To Promptly Pay My Doctors Bill Directly. I Further Understand And Agree If I Fail To Make Prompt And Timely Payments To **PAOF** I Will Be Directly Responsible For Any And All Costs Of Collection Including Filing Fees As Well As Reasonable Attorney Fees. I Hereby Authorize **PAOF** To Release To My Insurance Company Any Information Acquired, Including The Diagnosis And The Records In Course Of My Examination And Treatment. I Acknowledge That I Was Provided A Copy Of The Notice Of Privacy Practices And Have Read (Or Had The Opportunity To Read If I Chose) And Understand The Notice.

I CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. **Initial:**_____ **Date:**_____