Patient Information

Please Print Date:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____

Email Address:_____

Sex:_____ Race:_____ Ethnicity:_____

Preferred Language:_____ Social Security #:_____

Height:_____ Weight:_____ Shoe Size:_____

Marital Status:_____ Referred By:_____

Employer:_____ Occupation:_____

Phone:_____ Address:_____

City:_____ State:_____ Zip:_____

Person Responsible for Payments (if different from patient):

Name:_____ Date of Birth:_____

Relationship to Patient:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____

Social Security #:_____

Emergency Contact:

Name:_____ Relationship:_____

Phone:_____ Email:_____

Address:_____

City:_____ State:_____ Zip:_____

Communication: Circle all that apply:

Home Phone Mobile Phone Work Phone Email Mail

Insurance:

Primary:_____ ID:_____

Secondary:_____ ID:_____

I authorize the release of any medical information necessary to process an insurance claim.
-and-
I authorize payment of benefits, either to myself, or Dr. Michele L Selsor as agreed upon at the time of services rendered and/or according to contract with my insurance company. I agree that I am responsible for and will pay any deductibles or copayments as contracted with my insurance company.
-or-
<u>If you are NOT using insurance:</u>
I am solely responsible for and agree to pay the incurred charges received by the doctor.

Signature:_____ Print:_____

Medical History for:_____

Primary Doctor: Name:_____ Phone:_____

Check all that apply:

❑ AIDS/HIV	❑ Anemia	❑ Angina	❑ Arthritis
❑ Artificial heart valves	❑ Artificial joints	❑ Back problems	❑ Bleeding disorders
❑ Cancer	❑ Chemical dependency	❑ Chest pain	❑ Chronic diarrhea
❑ Circulatory problems	❑ COPD	❑ Diabetes	❑ Ear problems
❑ Epilepsy	❑ Eye problems	❑ Fainting	❑ Foot/leg cramps
❑ Gout	❑ Headaches	❑ Heart disease	❑ Hemophilia
❑ Hepatitis	❑ Jaundice	❑ High blood pressure	❑ Kidney problems
❑ Liver disease	❑ Low blood pressure	❑ Nervous problems	❑ Phlebitis
❑ Psychiatric care	❑ Radiation treatment	❑ Rash	❑ Respiratory disease
❑ Rheumatic fever	❑ STD	❑ Shortness of breath	❑ Special diet
❑ Stroke	❑ Swelling in feet/ankles	❑ Swollen neck glands	❑ Tired feet
❑ Tuberculosis	❑ Ulcers	❑ Varicose veins	❑ Unexplained weight loss

Any others:_____

Smoking Status

❑ Non-smoker ❑ Former smoker ❑ Current smoker

If current smoker, how frequent:_____

Please list any surgeries you have had:

_____

_____

Please list your current medications:

_____

_____

Please list any allergies:

_____

Preferred Pharmacy:_____ **Phone:**_____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremities from the knee down.

Signature:_____

Please Print:_____

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 Dr. Michele L Slesor, D.P.M, it may be medically necessary to obtain blood, urine, stool, tissue, or other types 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 be transferred to a third party for cleaning or disposal.

By Signing this document, you affirmatively state that it is your intentional decision to sensent to the transfer of any and all biological specimens collected by or deposited with Michele L. Selsor, D.P.M 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 of Patient

_____
Printed Name of Patient

_____
Date

Acknowledgement of Receipt of Notice of Privacy Practices
(Pg 7-12)

Patient Signature:_____

Print:_____

Parent or Authorized Representative (if applicable)

Signature:_____

Print:_____