Dr. Dawn Miles
PODIATRY

320 Zeagler Drive, Ste. B
Palatka, Florida 32177
Telephone: (386) 328-7228
Fax: (386) 328-3351

8640 Phillips Hwy Ste 10
Jacksonville, FL 32256
Telephone: (904) 469-2432
Fax: (904) 240-4425

1851 Old Moultrie Road
St. Augustine, Florida 32084
Telephone: (904) 808-9950
Fax: (386) 328-3351

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____ **Date:** _____

Primary Care Doctor: _____

Birthdate: _____ **SEX:** Male / Female **SS#:** _____ **Age:** _____

Marital Status: (please circle) Single Married Widowed Separated Divorced

Employment Status: (please circle) Employed Unemployed Retired Student

Preferred Language: _____

Address: _____

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

Home Phone: _____ **Cell:** _____ **Work:** _____ **Ext:** _____

Email: _____

Best time to reach you: _____ **Location:** _____

Occupation: _____ **Employer:** _____

Employer Address: _____

Emergency Contact Name: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

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INSURANCE INFORMATION **Date:** _____

Patient Name: _____

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co. _____ **Group #:** _____ **Policy #:** _____

Subscriber Name: _____ **Birthdate:** _____ **SS#:** _____

Is patient covered by additional insurance? ____ Yes ____ No

Subscriber Name: _____ **Relationship to patient:** _____

Insurance Co: _____ **Group #:** _____ **Policy #:** _____

Race: (please circle) American Indian or Alaska Native Asian Black or African American Chinese Decline to Disclose Filipino Guamanian or Chamorro Japanese Korean Native Hawaiian or Other Pacific Islander Other Asian (example Hmong, Laotian, Thai) Other Race Other Pacific Islander (example Fijian, Tongan) Samoan Vietnamese White Prohibited by law

Ethnicity:(please circle) Cuban Decline to Disclose Hispanic or Latino Unknown Mexican, Mexican American, Chicano Not Hispanic or Latino Puerto Rican Prohibited by law

Spouse's Name: _____ **Birthdate:** _____ **SS#:** _____

Whom may we thank for referring you today? _____

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Patient Name: _____ **Date:** _____

SOCIAL HISTORY

SMOKING Have you ever smoked? Yes / No Start date:_____ Stop date:_____

If current, how many packs per day? _____ # of years? _____ Are you interested in quitting? Yes / No

DRUG USE Do you take illegal drugs or illegal Rx medications? Yes / No If yes, explain? _____

ALCOHOL Do you drink alcohol? Yes / No If yes, how many drinks on a typical day? _____

ALLERGIES

____ Adhesive / Tape	____ Anticoagulant therapy	____ Aspirin	____ Codeine
____ Demerol	____ Local anesthesia	____ Novocain	____ Other (please list below)
____ Penicillin	____ Seafood	____ Sulfa	____ **NONE**

Other Allergies:_____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh, and hip complaints)

_____

_____

Have you ever been to a podiatrist before? ____ Yes ____ No

Athletic activities in which you participate (please list and indicate frequency) _____

_____

PLEASE INDICATE WHICH FOOT PROBLEMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

Ankle Pain	____ Yes ____ No	Athlete's Foot	____ Yes ____ No	Bunions	____ Yes ____ No
Corns and Calluses	____ Yes ____ No	Flat Feet	____ Yes ____ No	Foot or leg cramps	____ Yes ____ No
Heel Pain	____ Yes ____ No	Ingrown toenails	____ Yes ____ No	Numbness in the feet and legs	____ Yes ____ No

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Patient Name: _____ **Date:** _____

FAMILY HISTORY (Please circle all that apply)

Mother	**Heart Attack**	**Age:**_____	**Heart Disease**	**Stroke**	**Age:**_____	**Diabetes**
Father	**Heart Attack**	**Age:**_____	**Heart Disease**	**Stroke**	**Age:**_____	**Diabetes**
Grandparent	**Heart Attack**	**Age:**_____	**Heart Disease**	**Stroke**	**Age:**_____	**Diabetes**
Other:_____	**Heart Attack**	**Age:**_____	**Heart Disease**	**Stroke**	**Age:**_____	**Diabetes**

Surgical History (Please circle all that apply & list date)

Appendectomy _____
Amputation _____
Body Part: _____
Back (fusion / discectomy)_____
Fracture Repair Ankle R or L _____
Fracture Repair Foot R or L _____
Gallbladder _____
Gastric bypass _____
Heart Bypass _____
Hernia Repair_____
Hysterectomy _____
Intestinal _____
Joint Replacement _____
Joint: R or L _____
Stents-Leg _____
Stents- Cardiac _____
Tonsillectomy _____

Other surgeries & dates: _____

_____

_____

Hospitalizations other than for the surgeries listed: _____

_____

_____

Are you now or have you been under any other doctor's care in the past 2 years?

____ Yes ____ No **If yes, please explain:** _____

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PAST OR PRESENT ILLNESSES (Please circle all that apply)

ADHD
AIDS/HIV
AFIB
Alzheimer's
Anemia
Aneurysm- Aortic
Aneurysm- Brain
Angina/Chest pain
Arrhythmias
Arthritis
Artificial joints
Artificial valve
Asthma
Back problems
Bleeding disorder
Blindness
Cancer
Type:_____
Chemotherapy
Circulatory issues
Clotting Problems
COPD
Coronary artery disease
Diabetes
DVT
Emphysema
Epilepsy
Eye problems
Fibromyalgia
GERD
Gout
Headaches
Hearing loss
L R Both
Heart attack
Age:_____
Heart Murmur
Hepatitis
Type:_____
High blood pressure
High cholesterol
High triglycerides
Hyperthyroid
Hypothyroid
Kidney failure
Liver disease
Low blood pressure
Low cholesterol
Low triglycerides
Macular degeneration
Mitral valve Prolapse
Multiple sclerosis
Nervousness
Osteoarthritis
Site:_____
Osteoporosis
Parkinson's disease
Peripheral vascular disease
Phlebitis
Polio
Psychiatric disorder
Anxiety Bipolar
Depression OCD
Schizophrenia
Other:_____
Rash
Rheumatic fever
Rheumatoid Arthritis
Radiation treatment
Shortness of breath
Sinus problems
Sleep apnea
Special diet
Stroke Age:_____
Swelling feet/ankles
Swollen neck glands
Tired feet
Tuberculosis
Ulcers leg
Ulcers-stomach
Varicose veins
Venereal disease
Weight loss (unexplained)

Other chronic illness not listed: _____

_____

CONSENT

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 feet.

Patient Signature: _____ Date: _____

Patient Name: (Please print) _____

PATIENT MEDICATION LOG

Patient Name: _____ Date: _____

Date Of Birth: _____

_____NOT CURRENTLY TAKING ANY MEDICATIONS

	MEDICATION NAME	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Pharmacy: _____ **Location:** _____

CURRENT MEDICATIONS

Please sign your name on the line below if you consent to our physicians obtaining your prescription information from your pharmacy database. Information received is for patient care only and the information retrieved will become part of your HIPAA protected chart.

Patient Signature: _____

Check here ____ if you do NOT authorize us to obtain a list of medications from the pharmacy database.

(Please Note: In order to protect your health from potential contraindicated medication complications, our physician will not be able to write any prescriptions for any patient who has not given consent to obtain a full Rx medication list.)

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ASSIGNMENT, AUTHORIZATIONS, AND RELEASES

I authorize Dawn S. Miles, DPM to release to any insurance company or government agency (example: Blue Cross/Blue Shield or Medicare) any medical information contained in my records when such material is required in connection with determining a claim for payment. I authorize Dawn S. Miles, DPM to release any medical information accumulated in the course of my examination or treatment to any other treating doctor, hospital, or nursing home. I furthermore authorize Dawn S. Miles, DPM to release any medical or financial information related to the care given to me by Dawn S. Miles, DPM to any authorized insurance company, attorney, claim adjuster or credit agency. I authorize the release of any medical information contained in any other doctor, hospital, or pharmacy records to: Dawn S. Miles, DPM.

INSURANCE

I authorize payment from my insurance company or any governmental agency (example: Blue Cross/Blue Shield, Medicare) directly to Dawn S. Miles, DPM for any medical or surgical benefits otherwise payable to me for the services of Dawn S. Miles, DPM but not to exceed the reasonable and customary charges for these services. I authorize payment as a direct assignment of my rights and benefits under my insurance policy. I instruct and direct my insurance carrier to pay by check made out and mailed to:

Dawn S. Miles, DPM
PO Box 368
East Palatka, FL 32131-0368

AUTHORIZATION OF CARE AND ACKNOWLEDMENT OF RESPONSIBILITY FOR PAYMENT

I authorize Dawn S. Miles, DPM to examine me and order such tests and perform such procedures are reasonable and necessary in the diagnosis and treatment of my care. I agree to pay the amount of any insurance benefits be insufficient to cover the professional fees of my care, and I will be responsible for the payment of the difference including any deductibles and co-payments. If my professional fees are not covered by insurance benefits I agree to pay the entire amount of my professional fees. I agree to the payment of any court costs and attorney's fees that may be incurred by Dawn S. Miles, DPM in the collection process if my account becomes delinquent.

DURABLE MEDICAL EQUIPMENT

Although we make every attempt to obtain insurance benefits ahead of time, it is not always possible. Benefits for durable medical equipment is often different from office visits. As a result of this you may be billed separately for any equipment dispensed. Durable Medical Equipment is not refundable or returnable.

Patient Signature: _____ Date: _____

Patient Name: (Please print)_____

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INSURANCE RELATED PAPERS

We are dedicated to providing your health insurer with all the billing related papers and letters needed to process your claims. This is at no cost to you. Many patients have disability policies or may qualify for the Family Medical Leave Act. These papers require an attending physician statement and are very tedious and time consuming. We regret we must charge a fee of $10-$30.00 for each of these statements depending on the complexity of the forms.

CANCELLATION POLICY

All cancellations or rescheduling require a ***32 hour notice*** or they will be subject to charges. If less than a ***32 hour notice*** is given, or you are a ***NO SHOW***, you will be charged a fee of ***$25.00***.

PAYMENT OPTIONS

We accept payment in the form of ***cash*** or ***check***. If your check is ***returned*** there will be a ***$30.00*** charge. For your convenience we also accept ***Credit, Debit, or Health Saving Account*** with a ***3% convenience fee*** added to your total.

Patient Signature: _____ Date: _____

Patient Name: (Please print) _____

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____ Date of Birth: _____
(Please Print)

I request that all communications to me (by telephone, mail, or otherwise) by Dr. Dawn Miles and/or it's staff be handled in the following manner:

- For written communications: Address to: _____
  _____
  _____
  _____
- For oral communications: Call: _____
  (telephone number)

  May we leave a message?
  ___ Yes ___ No

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____
_____
_____

_____ _____
Patient Signature Date

For Practice Use Only
Practice: _____ Accepts _____ Denies
Privacy Officer Signature: _____ Date: _____

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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.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

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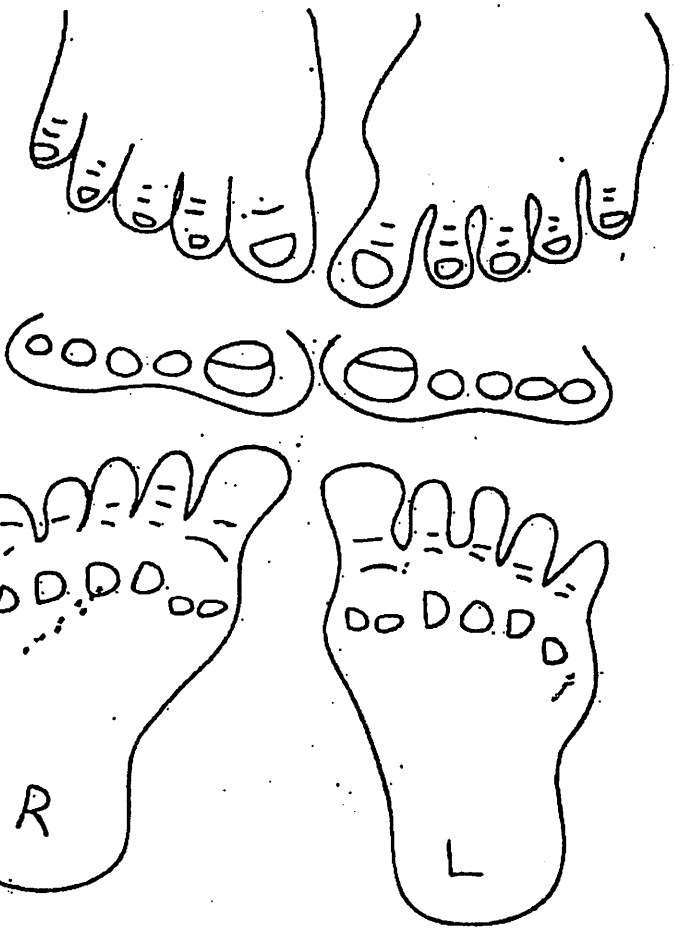
Patient's Name: _____ Date: _____

Where Does It Hurt?

On the diagram below please mark the place(s) where you are experiencing pain in your feet.



Regarding the place(s) you marked above, describe the pain you experience, for instance mild, moderate, severe, throbbing, burning, etc: _____

_____

_____