SHORES
PODIATRY ASSOCIATES
Foot Specialists • Surgeons • Wound Care Specialists

Kevan R. Kreitman, DPM
David R. Calderone, DPM
Michelle M. DeYoung, DPM
Bryan C. West, DPM
Andrew R. Mastay, DPM

PATIENT INFORMATION

The Doctors and their staff wish to welcome you to our office. Please answer all questions below to help us become better acquainted. If you need any help, please do not hesitate to ask.

Name _____ Birth Date _____

Race: ❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian ❑ Native Hawaiian/Pacific Islander

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Primary Medical Physician name and phone number _____

Assignment and Release:

I, the undersigned (or my dependent), assign all insurance and Medicare benefits to Shores Podiatry Associates, P.C., for the podiatric, medical or surgical services received. I understand that I am responsible for payment of:

1) Services not paid by my insurance 2) Deductibles 3) Copayments

I authorize Shores Podiatry to release all information necessary to receive payment from my insurance company. I authorize the use of this signature on all insurance submissions.

I certify that the above information is correct, to the best of my knowledge. I give permission to the doctors of Shores Podiatry to do such procedures deemed in the diagnosis and treatment of my foot or ankle problem.

By signing this document, I agree, in order for Shores Podiatry Associates, P.C. to service my account or to collect any amounts I may owe, Shores Podiatry Associates, P.C. and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

I/We have read this disclosure and authorize express consent that Shores Podiatry Associates, P.C. its affiliates and third part service providers may contact me/us as described above.

Patient or Legal Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered the Notice of Privacy Practices.

AUTHORIZATION TO RELEASE PRIVATE HEALTHCARE INFORMATION:

By law, we are only authorized to speak directly with the patient regarding any form of private healthcare information which includes scheduled appointments, test results, medication, office visits, surgery, etc.

Please check below:

_____ I do not authorize Shores Podiatry Associates, P.C. to speak with anyone regarding my private healthcare information.

_____ I give Shores Podiatry Associates, P.C. authorization to speak with the individuals that I specify below regarding my private healthcare information.

Name	Relationship	Telephone Number

_____ _____

Patient Name *(please print)* Date

_____ _____

Signature Parent or Authorized Representative *(if applicable)*

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ADDITIONAL INFORMATION AS REQUIRED

Name _____ Birthdate _____

Influenza Vaccine

Check one that best fits:

_____ Received a flu vaccine this flu season.

_____ Did not receive a flu vaccine this flu season because of medical reasons.

_____ Did not receive a flu vaccine this flu season because I do not want one.

Pneumonia Vaccine **(for patients 65 and older)**

Check one that best fits:

_____ Received a pneumonia vaccine.

_____ Did not receive a pneumonia vaccine.

Do you have a Living Will or Advance Directive? YES_____ NO_____

(for patients 65 and older)

Patient Signature _____ Date _____