Dr. Paul A. Weiner
Podiatric Medicine and Surgery
15300 Jog Road, Suite 204
Delray Beach, FL 33446
Phone: 561 265-5424
Fax: 561 265-5418

PATIENT REGISTRATION FORM

Date: _____ Location: _____

Name: _____

Local Address: _____

Other Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Medical Doctor: _____ PCP's Phone #: _____

Past Surgical History: _____

Nature of Foot Problem: _____

Emergency Contact/Relationship: _____ Phone#: _____

Pharmacy: _____ Phone #: _____

Please indicate if you have any of the following:

____ Diabetes ____ Mitral Valve Prolapse _____ Murmur
____ Hypertension ____ Blood Condition (Phlebitis, Clotting Disorder, Gout)
____ Heart Ailment ____ Drug Allergies: _____
____ Medications: _____
____ Other: _____
____ Tobacco Use None ____ packs/day _____ Quit ____ Years Ago
____ Alcohol Use None Rarely Moderately Daily Quit

Height: _____ Weight: _____ Blood Pressure: _____

Assignment of Benefits:

I, the undersigned, certify that I have insurance coverage with _____, and assign directly to Weiner 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 my by insurance. I hereby authorize Dr. Paul A. Weiner to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all submissions.

Signature: _____

Dr. Paul A. Weiner
Podiatric Medicine and Surgery
15300 Jog Road, Suite 204
Delray Beach, FL 33446
Phone: 561 265-5424
Fax: 561 265-5418

ASSIGNMENT OF BENEFITS

Date: _____

Patient Name: _____

Local Address: _____

Other Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Medical Doctor: _____ PCP's Phone #: _____

Emergency Contact/Relationship: _____ Phone#: _____

Referred By: _____

Assignment of Benefits:
I, the undersigned, certify that I have insurance coverage with _____, and assign directly to Weiner 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 my by insurance. I hereby authorize Dr. Paul A. Weiner to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all submissions.

Signature: _____

Dr. Paul A. Weiner
Podiatric Medicine and Surgery
15300 Jog Road, Suite 204
Delray Beach, FL 33446
Phone: 561 265-5424
Fax: 561 265-5418

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third party payers.
Conduct normal healthcare operations such as quality assessments, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time an that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, and if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, and was unable to do so as documented below.

Date: _____ Initials _____

Reason(s): _____