

MICHAEL J. AYRES, D.P.M., P.A.

Confidential Patient Information

PLEASE PRINT PATIENT INFORMATION

Patient Name:	Date of Birth:
Address One:	Social Security#:
Alternate Add:	Male _____ Female _____
City:	M/S: Single __ Married __ Divorced __ Separated __ Widowed __
State: Zip:	Height: Weight:
Best Contact # (Business, Home, Cell) :	Shoe Size: Width:
Spouse/Guardian Name:	E-mail Address:
Spouse SSN:	Spouse Employer:
Spouse Date of Birth:	Spouse Employer Work Phone#:

EMPLOYER INFORMATION

Employer Name:	City:
Address:	State: Zip:
Phone#:	Occupation:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy#:	Policy#:
Group #:	Group#:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:

FAMILY DOCTOR: _____ **LAST VISIT:** _____

PHARMACY: _____ **LOCATION:** _____ **PHONE#:** _____

PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST.

If assignment is taken, I authorize my insurance and/or Medicare benefits to be paid directly to Michael J. Ayres, D.P.M., P. A. I authorize release of information acquired in the course of my treatment in order to process claims. I am financially responsible for all services rendered.

SIGNATURE: _____ **DATE:** _____

**Michael J. Ayres, D.P.M., P.A.
Waiver of Liability Advance Notice**

Medicare, *and all other private insurance companies* do not generally cover routine trimming of corns, calluses, and toenails after the first visit, unless certain medical conditions are diagnosed. (i.e. severe circulatory disorders).

Medicare, *and all other private insurance companies* may not cover certain services in a period of less than 61 days and also may not cover shoes, orthotic devices, insoles, and certain supplies such as foot strappings, pads, medications, and other miscellaneous supplies, unless certain medical conditions are diagnosed.

Beneficiary Agreement

I understand that I am responsible for and will be asked to pay for any non-covered services or supplies at the time of service. I understand that upon my second no showed appointment I will be responsible for a \$25.00 no show fee.

SIGNATURE: _____ **DATE:** _____

WELCOME!

Thank you for selecting our healthcare team! We strive to provide you with the best possible healthcare. To help us meet your healthcare needs, please fill out these forms completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

**PATIENT MEDICAL HISTORY
Please Print**

Patient Name:

Account #:

DOB:

What name would you prefer to be called? _____

How did you hear about our office? (please circle one):

Physician / Word of Mouth / Yellow Pages / Yellow Book / Sign / Newspaper / Website / Internet

Other: _____

If you circled Physician or Word of Mouth: Whom may we thank for referring you to our office?

Name: _____

At the time your appointment was made were you informed of our website: drmayres.com? yes_____ no_____

What is your main foot or ankle complaint? _____

When did this complaint begin? _____

Past Medical History (Please check all that apply)

Are you pregnant or a possibility you might be pregnant? _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Valve disease/ Replacement | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Arthritis conditions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Blood clotting abnormalities | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Cardiac disease | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Kidney problems/Dialysis | <input type="checkbox"/> Stomach Reflux |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deep Vein Thrombosis(DVT) | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> History of MRSA | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes Type 1__ Type 2__ Diet__ | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Ulcer (stomach or duodenal) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Fracture, where? _____ | <input type="checkbox"/> Polio | <input type="checkbox"/> Vascular disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cancer, what type? _____ |
| <input type="checkbox"/> Other problems not listed? _____ | | |

List **medications** taken regularly? _____

What **surgeries** have you had in the past? _____

Allergies or sensitivities (Please circle all that apply, and what reaction you had)

- | | | |
|---|--|---|
| <input type="checkbox"/> None known | | <input type="checkbox"/> NSAID's reaction? _____ |
| <input type="checkbox"/> Acetaminophen reaction? _____ | <input type="checkbox"/> Demerol reaction? _____ | <input type="checkbox"/> Penicillin reaction? _____ |
| <input type="checkbox"/> Adhesive tape reaction? _____ | <input type="checkbox"/> Erythromycin reaction? _____ | <input type="checkbox"/> Prednisone reaction? _____ |
| <input type="checkbox"/> Aspirin reaction? _____ | <input type="checkbox"/> Iodine reaction? _____ | <input type="checkbox"/> Sulfa drugs reaction? _____ |
| <input type="checkbox"/> Betadine reaction? _____ | <input type="checkbox"/> Latex reaction? _____ | <input type="checkbox"/> Tetracycline reaction? _____ |
| <input type="checkbox"/> Cephalosporins reaction? _____ | <input type="checkbox"/> Local anesthetics reaction? _____ | <input type="checkbox"/> X Ray dye reaction? _____ |
| <input type="checkbox"/> Codeine reaction? _____ | <input type="checkbox"/> Morphine reaction? _____ | |

Social History (Please circle)

Do you smoke? Yes / No / Quit How Much? _____ How Long? _____

Drink Alcohol? Yes / No / Quit How Much? _____

Do (or did) you take recreational drugs? Yes / No

MICHAEL J AYRES, DPM, PA
910 MALABAR ROAD, SE, SUITE 1
PALM BAY, FL 32907
321-722-0000

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:
Patient Name:
Address:

I understand and am aware of the Notice of Privacy Practices. If I so choose, a copy of the Notice is available to me by request.

PARENT OR AUTHORIZED REPRESENTATIVE (if applicable)

SIGNATURE: _____

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Michael J. Ayres, DPM, PA and Dr. Michael J. Ayres and his staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Conditions for Disclosure (Check the item(s) that apply):

- The practice may disclose my personal health information to the individual(s) above **only** in my presence.
- The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.
- Other Conditions of Disclosure: _____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____

Witnessed by: _____ Title/Position: _____

Printed Name of Witness: _____

Date: _____