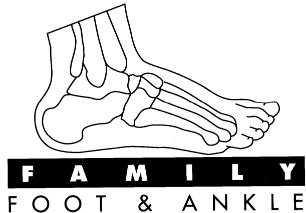
Please visit us at:
www.drmayres.com



Michael J. Ayres, DPM
Podiatrist/Foot & Ankle Surgeon

910 Malabar Road SE, Suite 1
Palm Bay, Florida 32907

321-722-0000
Fax 321-768-0085
mayresca@bellsouth.net
www.drmayres.com

Member: American Podiatric Medical Association, Florida Podiatric Medical Association. Diplomate, American Board of Podiatric Surgery. Fellow, American College of Foot & Ankle Surgeons. Diplomate, American Board of Podiatric Othopedics.

FOR THE HEALTH OF YOUR FEET:

- Diabetic foot care / shoes
- Complex wound management
- Reconstructive foot & ankle surgery
- Foot fracture care
- Insole/Orthotic devices
- Digital X-ray
- Heel pain management
- Ingrown toenail care
- Diagnostic Ultrasound

FOR YOUR CONVENIENCE:

- 24-hour emergency care
- Most insurances accepted and filed
- Mastercard, Visa, Debit welcome

Hello!

Attached please find your NEW PATIENT paperwork for our office.

We ask that after all forms are completed that you return them to our office via mail, FAX (768-0085) or simply dropping them off to us PRIOR to your appointment.

Please arrive **15 minutes early so that we may enter any additional information **PRIOR** to your appointment time.

We look forward to offering our services to you.
Have a great day!!

We Care For People….Not Just Feet!

MICHAEL J. AYRES, DPM, PA

Appt: **Time:**

Confidential Patient Information **** Please ARRIVE 15 mins EARLY**

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 Phone # (Home, Cell, Work) :	Shoe Size: Width:
Preferred Language:	E-mail Address:
Race:	Spouse/Guardian Name:
Ethnicity (Circle): Hispanic/Latino Non-Hispanic/Latino	Spouse phone #

EMPLOYER INFORMATION

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

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy#:	Policy#:
Group #:	Group#:
Subscriber Name:	Subscriber Name:
Subscriber D.O.B:	Subscriber D.O.B:

FAMILY DOCTOR:__________________________________**PHONE:** _______________

PHARMACY: ____________________ **LOCATION:** _____________ **PHONE#:**_____________

Emergency Contact: _____________________ **Relation**: _____________ **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 assume responsibility for payment of any balance on my account including collection fees.

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.

SIGNATURE:_____________________________________ **DATE:** _____________

FAMILY
FOOT & ANKLE

MEDICATION LIST

Name:	Address:
Phone Number:	
Birth date:	Primary Doctor:

Allergic To/Describe Reaction:	Allergic To/Describe Reaction:

Name of Medication	Dose	Directions: How often do you take this medicine?	Date Stopped	Reason for taking / MD Name

WELCOME!

PATIENT MEDICAL HISTORY

Please Print

Patient Name: ______________________________ **DOB:** ________________

Whom may we thank for referring you to our office?
Name: ________________________________

What is your main foot or ankle complaint?
____

When did this complaint begin? __________________________

Past /Current Medical History (check all that apply)
Are you pregnant or a possibility you might be pregnant? ___________

□ Anemia
□ Arthritis conditions
□ Asthma
□ Blood clotting abnormalities
□ Cardiac disease
□ Circulation problems
□ Congestive heart failure
□ DeepVein Thrombosis(DVT)
□ Depression
□ Diabetes Type 1__ Type 2__ Diet__
□ Fibromyalgia
□ Fracture, where?___________
□ Gout
□ Other problems not listed?
____

□ Heart Valve disease/ Replacement
□ Hepatitis
□ High cholesterol
□ HIV/ AIDS
□ Hypertension (high blood pressure)
□ Kidney problems/Dialysis
□ Lung disease
□ Migraines
□ History of MRSA
□ Neuropathy
□ Phlebitis
□ Polio
□ Psoriasis

□ Respiratory problems
□ Rheumatic Fever
□ Seizure disorder
□ Sickle cell
□ Skin problems
□ Stomach Reflux
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Ulcer (stomach or duodenal)
□ Varicose veins
□ Vascular disease
□ Cancer, what type?_________

List ALL Surgeries you've had in your ENTIRE life:

____

____

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

Family: (Please circle)
Mother – living or deceased - Age: ____ Medical problems and/or reason for death: ____________________________
Father – living or deceased - Age: ____ Medical problems and/or reason for death: ____________________________

Living Situation: Alone / With spouse / Assisted Living / With Relative # of Children that you have - _______

Type of Exercise: ____________________ How many times per week: _________

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: ________________________

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.

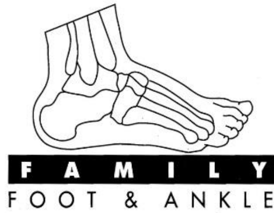
Patient Signature: ____

Date of Signature: ____

Witnessed by: ____________________________________ Title/Position: ________________________

Printed Name of Witness: __________________________

Date: __________________________



CANCELLATION & NO-SHOW POLICY

If you do not show up for your appointment AND if you have not cancelled your appointment at least 24 hours (1 full day) in advance, Dr. Ayres will charge you a "no-show fee". The amount of the no-show fee will depend on the nature of your scheduled visit. For example, missed follow-up visits will result in a $25 no show fee. A no-show fee is a separate charge that will not be covered by your insurance plan.

BEFORE CHARGING YOU A NO-SHOW FEE, DR. AYRES MAY CONSIDER EXTENUATING CIRCUMSTANCE ON A CASE BY CASE BASIS.

You will need to pay the no-show fee in full before you schedule any future appointments.

WHY WE CHARGE A NO-SHOW FEE: A patient who does not show up for their appointment and who had not cancelled their appointment with at least 24 hour advanced notice affects the care we provide our other patients and the cost of care. Each no-show represents a missed opportunity for another patient to see the doctor. Every no-show is inconsiderate and costs Dr. Ayres time and money.

I understand Dr. Ayres' no-show policy and agree to pay the no-show fees above if I am a no- show and did not call the office at least 24 hours in advance of my appointment to cancel.

APPOINTMENT REMINDERS

As a courtesy we provide two types of appointment reminders. First, when leaving our office we will give you an appointment card with a day, date and time for your next appointment. Second, you will receive a courtesy call approximately two days prior to your next scheduled appointment, reminding you of your appointment. Do not rely solely on the call as this is a computer generated call. Dr. Ayres has done as much as he can do ensure you are reminded of your scheduled appointment, the rest is up to you.

Patient's Name (PRINT) Patient's Signature Date

_______________________________________ _________________________________ _____________

Responsible Person's Name (PRINT) Responsible Person's Signature Date

(FOR MINORS)

_______________________________________ _________________________________ _____________