GREGG HARRIS, DPM. PA
9980 Central Park Blvd. North Ste.106
Boca Raton, FL 33428
(561)488-3338 fax (561)488-1540
www.drgreggharris.com

PATIENT INFORMATION

Name: _____ **Date of Birth** _____ **Age:** _____

Address: _____
Street Apt.# City State Zip

Seasonal Address: (If different than above address)

Address: _____
Street Apt.# City State Zip

Sex: **M** **F** **Marital Status:** Married Single Divorced Separated Widowed Partnered

Phone: **Home** ( )_____ **Work** ( )_____ **Cell** ( )_____

Email: _____

What is your primary language? _____

Please specify your race _____American Indian or Alaska Native _____Asian _____White

_____Black or African American _____Native Hawaiian or Other Pacific Islander _____Prefer Not to Answer

Please specify your ethnicity _____Hispanic _____Non-Hispanic _____Prefer Not to Answer

Who is your primary care physician? _____
City Phone number

Who referred you to our office? _____

Emergency Contact:

Name: _____ **Relationship:** _____

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Responsible Party of Primary Insurance Carrier (If Not Self):

Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Apt.# City State Zip

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Employer: _____ Employer Phone: _____

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History & Medical Information

Patient Name: _____

What is your Height? _____ **What is your weight?** _____ **What is your shoe size?** _____

Allergies / Sensitivies: (Please circle all that apply) **None Known** Penicillin Sulfa Drugs Aspirin Codeine Latex

Adhesive Tape Advil Anesthesia Narcotics X-ray Contrast / Dyes Iodine Shellfish Other:_____

List all Medications / Vitamins / Herbs / Supplements: _____

_____ Aspirin? Yes No

Past Medical History: (Please circle all that apply)

Anemia	Chemical Dependency	Kidney Disease	Prostate Disorders
Artificial Joints	Epilepsy	Liver Disease	Psoriasis
Asthma	Gout	Lung Disorders	Psychiatric Care
Anxiety	Heart Disease	Mitral Valve Prolapse	Stomach Ulcer
Bleeding Disorders	Heartburn / Reflux	Nerve Disorders	Spinal Stenosis
Blood Clots/ Phlebitis	Hepatitis	Osteoarthritis	Swelling Feet / Legs
Cancer:_____	High Cholesterol	Raynaud's Disease	Stroke
Radiation Treatment	High Blood Pressure	Rheumatoid Arthritis	Thyroid Disorders
Diabetes	HIV / Aids	Parkinson's	Other:_____
Neuropathy	Kidney Disease	Poor Circulation	_____

_____

Have you ever had surgery? YES NO (Please list any and all)_____

_____

_____

Social History: (Please circle all that apply) Current Smoker Yes No How much?_____ Past Smoker Yes No

Alcohol Use Yes No How Much? _____ Drug Use Yes No (recreational or IV)

Pregnant? Yes No Nursing? Yes No

_____

Family Member ever had any of these problems? (circle all that apply) Diabetes Foot Problems Gout Arthritis

Bleeding Disorders Cancer Heart Disease Kidney Disease Stroke

Other and Details: _____

_____

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ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to Dr. Gregg Harris. This authorization is valid until I notify Dr. Gregg Harris in writing that it is revoked.

I understand that I am responsible for giving the office of Dr. Gregg Harris the correct insurance information at the time services are rendered. Dr. Gregg Harris agrees to bill your primary insurance carrier. If you have more than one insurance, we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary insurance within 45 days, the balance becomes your responsibility. All insurance information must be provided to our office at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance Company due to my failure to obtain the required referral.

I authorize the release of medical information necessary to process my claim.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that the office of Dr. Gregg Harris is not responsible for knowing if the physician is a participating provider with my insurance carrier.

We at the office of Dr. Gregg Harris expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10.00 re-billing fee for each additional statement sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a $25.00 fee for all returned checks.

I understand that if I do not call to cancel my appointment at least 24 hours prior to the appointment, there may be a $25.00 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance, including deductibles, co-pays, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside agency that I shall be liable for all costs, attorney or collection fees, and any other fees and or court costs incurred by this office.

I have read and understand the above policies.

_____

Patient or Patient's Guardian or Legal Representative Signature Date

_____

Printed Name of Patient or Guardian or Legal Representative Relationship to Patient

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Please answer for federal HIPAA compliance - (Privacy Act)

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine or voicemail? (Please circle) YES NO

May we send electronic copy of Continuity of Care Document (CCD) to your email? (Please circle) YES NO

With whom do you allow us to share your health information if you are unavailable?

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Advanced Care Plan

Do you have a Living Will? YES NO
(Please Circle)

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 (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name ***(please print)*** **Date**

_____
Parent or Authorized Representative (if applicable)

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Dr. Gregg Harris of any changes to the above information.

_____ _____
Patient or Guardian Signature **Date**

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Patient Name: _____

What specific problem brings you to our office today?_____

How long ago did this problem start?_____ Days / Weeks / Months / Years

Did it start after a particular activity or event?_____

Did the pain or problem: _____Begin all of a sudden _____Gradually develop over time

How would you describe your pain or symptom? _____No pain _____Sharp _____Dull _____Aching

_____Burning _____Radiating _____Itching _____Stabbing _____Tingling

Other:_____

How would you rate your pain on a scale from 1 to 10? (please circle)
(*no pain*) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the problem or pain started has it: _____Stayed the same _____Become worse _____Improved

What makes you pain or problem feel worse? _____Walking _____Standing _____Running _____Rest

_____Daily activities _____Flat shoes _____High heels _____Any closed toe shoe _____Dress shoes

Does it feel better if you get off of your feet? Yes No Does it hurt at night? Yes No

Do you walk barefoot on tile? Yes No Do you work on hard floors / concrete all day? Yes No

What makes your problem or pain feel better? _____

What treatments have you had for this problem? _____

Was this problem caused by an injury? _____Yes _____No (describe) _____
If yes, was it a work-related injury? _____Yes _____No

Completed by: _____ Date: _____

NAME:_____ DATE:_____

WE ARE UPDATING OUR COMPUTER TO MAKE AUTOMATED APPOINTMENT REMINDERS.

PLEASE SUPPLY THE FOLLOWING:

HOME PHONE:_____
CELL PHONE:_____
EMAIL ADDRESS:_____

HOW WOULD YOU LIKE TO BE NOTIFIED FOR APPOINTMENT REMINDERS.

PLEASE CHECK ONLY ONE.

_____TEXT TO YOUR CELL PHONE

_____CALL TO YOUR CELL PHONE

_____CALL TO HOME PHONE

_____EMAIL REMINDER

THANKS FOR YOUR ASSISTANCE.

DR. GREGG HARRIS AND STAFF

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Office Policy for Missed Appointments

Due to the fact that recently many people have not shown up for appointments, and have not had the courtesy to call prior, we have found it necessary to institute a policy for missed appointments.

When an appointment is given for the type of treatment to be rendered to a particular patient, we dedicate 15-60 minutes of our office time depending on what is to be done. When a patient fails to give us at least 24 hour notice prior to not attending their appointment, we are unable to schedule one of our other patients for that time slot.

A vast majority of our patients understand that in the present medical climate, we have little room for loss of revenue associated with the loss of appointment time slots.

This letter acknowledges that you understand that there will be a **$ 35.00** charge for missed appointments when **24 hour notice** has not been given to our office.

We understand that life has issues, and exceptions will be made on a case by case basis for illness, and emergencies.

Thank you for your understanding.

Patient Signature:_____

Date:_____