Delray Podiatry Foot & Ankle Group, Inc.

Michael B. Sturm, D.P.M.

NAME_____DATE_____
FLORIDA ADDRESS_____
CITY_____STATE_____ZIP_____PHONE#_____
Date of Birth_____ AGE_____ SS#_____CELL#_____
ADDRESS ALTERNATE/NON-SEASONAL _____
CITY_____STATE_____ ZIP_____ OCCUPATION#_____
NAME OF MEDICAL DOCTOR_____LAST APPOINTMENT_____
MARITAL STATUS_____ SPOUSES NAME_____
SPOUSE'S EMPLOYER_____ EMAIL ADDRESS _____
REFERRED BY:_____

REASON FOR TODAY'S VISIT:

_____

_____

MEDICAL HISTORY - PLEASE X BOXES THAT APPLY:

[ ] Diabetes	[ ] Hearing	[ ] Asthma	[ ] Chest Pain
[ ] Ulcers	[ ] Gout	[ ] Thyroid	[ ] Seizures
[ ] Heart Murmurs	[ ] Heart Disease	[ ] Tuberculosis	[ ] Dizziness
[ ] Glaucoma	[ ] Emphysema	[ ] Hepatitis	[ ] Malignancies___
___			
[ ] Rheumatic Fever	[ ] Phlebitis	[ ] Arthritis_____	[ ] Anemia
[ ] Joint Pain_____	[ ] Blood Disease	[ ] Strokes	[ ] Bronchitis
[ ] liver Disease	[ ] Kidney Disease	[ ] Low Blood Pressure	[ ] Respiratory Distress
[ ] Neurological	[ ] Venereal Disease	[ ] Aids	[ ] Cancer_____
[ ] High Blood Pressure	[ ] Cholesterol	[ ] **Other_____**	

INSURANCE COMPANY: _____POLICY HOLDER'S NAME:_____
INSURANCE ID#_____INSURANCE GROUP:_____
SECONDARY INS. COMPANY:_____ POLICY HOLDER'S NAME:_____
INSURANCE ID #_____INSURANCE GROUP #_____

I hereby authorize treatment by Michael Sturm, DPM, or an associate. I authorize release of any medical information necessary for processing insurance claims and allow photocopy of my signature for filing. I direct payment of medical benefits when advance payment in full has not been made. I understand that I am financially responsible for the fees for services rendered including collection fees and a finance charge of 1.5% per month on all overdue amounts.
I realize that it is my responsibility to verify with my insurance company that my doctors participate with my insurance plan. In addition,' many insurance plans require a referral, authorization, or use of an affiliated laboratory. If payment for my treatment is denied or reduced because I did not have a referral, authorization, or out-of-network services were provided, I will be personally responsible for all treatment costs. If payment has not been received from my insurance company within 45 days, for any reason, I understand that payment is due from me. I have received a copy of the Notice of Privacy Practices for his office.

Lifetime Signature:_____ Date _____

13590 Jog Road, Suite 2 * Delray Beach. Florida 33446 * (561) 865-3331

Delray Podiatry Foot & Ankle Group, Inc.

Michael B. Sturm, D.P.M.

Patient Name: _____ Date: _____

Pharmacy:	**Phone:**
Address:	

Current medications list:

Medication	Name	Dose:
Diabetes:		
High blood pressure:		
Cholesterol:		
Blood thinner:		
Diuretic:		
Other:		

Pertinent Surgeries and Date:

Physician list:

	Physician Name	**Phone**	**Date of last office visit**
Primary Care/Internist			
Cardiologist			
Endocrinologist			
Other			
Other			

Do you have any medication allergies: (Yes / No) if is yes, list medications _____ _____.

Do you use Alcohol (Yes / No) ___ None ___ Rarely ___ Socially___ Daily ___ How much_____

Do you Smoke (Yes / No) **Every day smoker** ____ or **Some day smoker** ____

Did you smoke before (Yes / No) **When did You Quit smoking?** _____

Have you had a Pneumonia Vaccine? (Yes / No)

Have you had a Covid -19 Vaccine? (Yes / No) ___ Moderna ___ Pfizer____Johnson & Johnson

Weight : Lbs. _____

Height : Feet ____ Inches ____

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PATIENT NAME: _____

Due to health insurance Portability and Accountability act {HIPPA} of 1966, the following information must be filled out by each patient annually.

MARITAL STATUS [Circle one]: Single/Married/Divorced/Widow[er]

ETHNIC GROUP (Circle one): Hispanic or Latino/Not Hispanic or Latino/Decline to Answer

RACE: BLACK OR AFRICAN AMERICAN/WHITE/ASIAN/AMERICANINDIAN OR ALASKA NATIVE/HAWAIIN OR PACIFIC ISLANDER/OTHER

I AUTHORIZE Delray Podiatry Foot & Ankle Group, Inc. to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends office visits and is in the room with me, I give Dr. Sturm and employees my permission to discuss freely, my condition, treatment, or diagnosis with that person.

O YES O NO

CANCELLATION/NO SHOW POLICY- Cancellations are requested 24 hours prior to your appointment. There will be a $30.00 charge for all cancelled appointments and a $50.00 charge for No Show appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Please select **PREFERRED** contact number:

O Home Phone _____May we leave a Message? YES/NO

O Work Phone_____ May we leave a Message? YES/NO

O Cell Phone _____May we leave a message? YES/NO

Would you like to receive Appointment confirmations via TEXT MESSAGES? YES/NO

Email: _____

(By giving us your email address, you are giving us permission to contact you in that matter for appointments, offers, and clinical news (NO SPAM)].

***Emergency Contact: _____Relationship _____**Phone: ( )_____

With whom may we discuss or release information about your care, treatment, or diagnosis?

Name: _____Relationship _____ Phone:( )_____

Name: _____Relationship_____ Phone:( )_____

PRIMARY CARE PHYSICIAN: _____Phone: ( ) _____

SIGNATURE: _____DATE: _____