Delray Podiatry Foot & Ankle Group, Inc.

13590 Jog Road, Suite 2, Delray Beach, FL 33446

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: _____