MELISSA C. VERDE, D.P.M., P.A.
1385 W. STATE ROAD 434 SUITE 103
LONGWOOD, FL. 32750
PHONE 407-332-6700 FAX 407-332-6226

DATE:_____ PATIENT ACCOUNT:_____

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME:_____ MI:____ LAST NAME:_____
DOB:_____ AGE:_____ SEX:_____ RACE:_____ ETHNICITY:_____
PRIMARY LANGUAGE:_____ OTHER LANGUAGE:_____
SOCIAL SECURITY:_____ MARITAL STATUS:_____
SPOUSE:_____

PATIENT CONTACT INFORMATION

ADDRESS:_____
CITY:_____ STATE:_____ ZIPCODE:_____
HOME PHONE:_____ CELL PHONE:_____
EMAIL:_____
PREFERRED METHOD OF CONTACT: _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE:_____

PRIMARY CAREGIVER:_____ RELATIONSHIP:_____ PHONE:_____
COMMENTS:_____

LEGAL GUARDIAN:_____ RELATIONSHIP:_____ PHONE:_____
COMMENTS:_____

HEALTHCARE PROXY:_____ RELATIONSHIP:_____ PHONE:_____
COMMENTS:_____

EMPLOYMENT INFORMATION

_____EMPLOYED_____UNEMPLOYED_____FULL TIME STUDENT_____PART TIME STUDENT _____DISABLED_____OTHER
EMPLOYER:_____ WORK PHONE:_____ EXT:_____
DEPARTMENT:_____ OCCUPATION:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIPCODE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ POLICY ID #:_____ GROUP#:_____
POLICY HOLDER NAME:_____ HOLDER DOB:_____ RELATIONSHIP:_____

SECONDARY INSURANCE:_____ POLICY ID #:_____ GROUP#:_____
POLICY HOLDER NAME:_____ HOLDER DOB:_____ RELATIONSHIP:_____

OTHER INSURANCE:_____ POLICY ID #:_____ GROUP#:_____
POLICY HOLDER NAME:_____ HOLDER DOB:_____ RELATIONSHIP:_____

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO I.D. FOR THE RECEPTIONIST TO COPY

Melissa C. Verde, D.P.M., P.A. 1385 W. State Rd. 434 Suite 103, Longwood, FL 32750 ph 407-332-6700 fax 407-332-6226

HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

AGE: _____ years HEIGHT: _____ ft _____ in WEIGHT: _____ lbs

REASON FOR TODAY'S VISIT: _____

PREVIOUS TREATMENT FOR THIS PROBLEM: _____

ALLERGIES: _____

CURRENT MEDICATIONS (PLEASE INCLUDE NAME, DOSE, AND FREQUENCY): _____

PREFERRED PHARMACY:

NAME: _____ LOCATION: _____ PHONE: _____

NAME: _____ LOCATION: _____ PHONE: _____

PRIMARY PHYSICIAN: _____ LAST VISIT: _____

SPECIALIST: _____ LAST VISIT: _____

SPECIALIST: _____ LAST VISIT: _____

SPECIALIST: _____ LAST VISIT: _____

PAST/CURRENT MEDICAL CONDITIONS:

___RECENT DECLINE IN HEALTH	___STOMACH/DIGESTIVE DISORDERS	___CANCER
___MIGRAINE HEADACHES	___AMPUTATION	___SCARRING TENDENCIES
___EYE PROBLEMS	___ARTHRITIS	___SKIN DISORDERS
___HEARING PROBLEMS	___BACK PROBLEMS	___SLOW HEALING WOUNDS
___ASTHMA / BRONCHITIS / COPD	___GOUT	___DIABETES
___SLEEP APNEA	___FIBROMYALGIA	___THYROID DISEASE
___OTHERBREATHING PROBLEMS	___PARALYSIS/MUSCLE WEAKNESS	___ANEMIA
___HEART MURMUR	___POOR BALANCE	___POOR CIRCULATION
___HEART ATTACK	___PREVIOUS FRACTURES	___HIV
___HEART PROBLEMS	___DEMENTIA	___BLOOD THINNERS
___HIGH / LOW BLOOD PRESSURE	___DEPRESSION/ANXIETY	___SICKLE CELL
___HEPATITIS	___EPILEPSY/SEIZURE DISORDER	___KIDNEY DISORDERS
___LIVER DISORDERS	___STROKE	___AUTOIMMUNE DISORDERS
___GASTRIC REFLUX	___NUMBNESS OF FEET	___OTHER

PLEASE EXPLAIN: _____

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HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

FAMILY HISTORY OF MEDICAL CONDITIONS:

MATERNAL GRANDPARENTS: _____ PATERNAL GRANDPARENTS: _____

MOTHER: _____ FATHER: _____

SIBLINGS: _____

CHILDREN: _____

OTHER: _____

SURGICAL HISTORY (PLEASE INCLUDE NAME OF PROCEDURE, DATE, AND SURGEON):

_____

_____

_____

_____

_____

_____

_____

COMPLICATIONS WITH ANESTHESIA? _____ WITH HEALING? _____

_____

_____

SOCIAL HISTORY:

___ALCOHOL ___TOBACCO ___RECREATIONAL DRUG USE ___ADDICTIONS

_____

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E-Prescribing/Medical History Consent Form

Dr. Melissa C Verde uses an electronic medical records system that allows electronic prescribing of medications. Prescriptions are sent to your pharmacy through a secure connection which improves the accuracy and timely transmission of medications and enhances patient safety.

The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an ePrescribe program.

These include:

- Formulary and benefit transactions--Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transaction--Provides the physician with information about previous and current medications the patient is taking to minimize the number of adverse drug reactions.
- Fill status notification--Allows the prescriber to receive an electronic notice from the pharmacy stating if the patient's prescriptions has been picked up or partially filled.

My signature certifies that I have read and understood the scope of my consent and that I authorize Dr. Verde to electronically prescribe and to access my medication history.

Patient Name Patient Signature Date

Melissa C. Verde, DPM PA
1385 W. State Rd 434 #103
Longwood, FL 32750
407-332-6700

RECORDS RELEASE FORM

TO: Whom It May Concern

RE: _____ _____
Patient Name DOB

I hereby authorize you to release to _____

any information, including the diagnosis and records of any treatment or examination rendered

during the period from _____ to _____.

_____
Signature

_____
Address

_____
City, State Zip

_____
Witness

RECORDS RELEASE FORM

MELISSA C. VERDE, D.P.M., P.A.
1385 W. STATE ROAD 434 SUITE 103
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PHONE 407-332-6700 FAX 407-332-6226

Financial Policy

I understand and agree that all fees are due at the time of service, unless previous arrangements have been made. I authorize Dr. Melissa C. Verde to release any medical information or records concerning diagnosis and treatment when requested for the use in determining a claim or payment to any third party such as, insurance companies or governmental agencies.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled; including Medicare, private insurance, and any other health plan to Dr. Melissa C. Verde.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Signature (patient/responsible party):_____ Date:_____
Relationship:_____ Date:_____

$35 Non-Sufficient funds fee will be charged for ALL RETURNED CHECKS.

$35 Missed appointment fee will be charged for missed/cancelled appointments without 24 hours notification to us.

A fee of 40%of the total outstanding balance will be charged for ALL DELINQUENT ACCOUNTS sent to collections.

I have read and understand the above statements and accept financial responsibility for these additional fees.

Signature (patient/responsible party):_____ Date:_____
Relationship:_____ Date:_____

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of the notice.

The law permits us to use or disclose your health information to those involved in your treatment. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one or more of our staff will enter your information into our computer.

We may share your medical information with our business associates such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may want to call and remind you of an appointment or to discuss details of a surgery with you. If you are not at home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request, in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact your from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for your copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, B.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint or for more information or assistance regarding your health information privacy, please contact our Privacy Office at (407) 332-6700.

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGEMENT

I have received a copy of the Notice of Privacy Practices for Melissa C. Verde, D.P.M.

Date:_____

Signature:_____ **Print name:**_____

If signing as a parent or guardian, please note the name of the patient:_____