Account #:_____
Date updated:_____

Info updated:_____
Any changes?:_____
Changes made on computer?:____

Donald S. Tanner, DPM, FACFAS

Patient Introduction

Last Name: _____ First Name:_____ M.I.:_____

Address: _____

City, State, Zip: _____

_____

Telephone: (Home): _____ Business: _____Cell:_____

S.S.#: _____ Date of Birth: _____ Age: _____

Sex: _____ Marital Status: _____ Next of Kin: _____

Employment Status: _____ Employer: _____

Address: _____

_____ Phone: _____

Referred By: _____

Primary Health Insurance: _____

Address: _____

I.D. #: _____ Group #: _____

Name of Insured: _____ D.O.B.: _____

Secondary Health Insurance: _____

Address: _____

I.D.#: _____ Group #: _____

Name of Insured: _____ D.O.B.: _____

Your Medical Doctor's Name: _____ Phone:_____

Are you allergic to any medications?_____
Are you taking any NEW medications?_____
Are you a Diabetic? _____

Do you have a personal or family history of any of the following diseases? (Indicate "P" for personal or "F" for familial)

_____ Arthritis
_____ Bleeding disorders
_____ Cancer
_____ Circulation problems
_____ Diabetes
_____ Gall Bladder disease
_____ Glaucoma
_____ Gout
_____ Heart disease
_____ High Blood Pressure
_____ Kidney disease
_____ Liver disease
_____ Neurologic disease
_____ Pancreatic disease
_____ Phlebitis
_____ Psychiatric disorder
_____ Respiratory disease (breathing problems)
_____ Thyroid disease
_____ Ulcers

Have you had major or minor surgery in your lifetime? If so, please list:

_____

_____

Are you currently taking any prescription medications? If so, please list:

_____

_____

Are you allergic to any medications? If so, please list:

_____

Do you use tobacco _____ or alcohol _____products?

I hereby authorize the doctor whose name appears above to furnish my insurance company all information which the insurance company may request concerning my present illness or injury. I also authorize the doctor to act in my behalf in all relations with the insurance company, and assign all benefits to which the doctor may be entitled.

Signature: _____ Date: _____

DONALD S. TANNER, D.P.M., F.A.C.F.A.S.

DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY
FELLOW, AMERICAN COLLEGE OF FOOT SURGEONS

Your insurance is a contract between you and your insurance company and/or your employer. The physician is not a party to that contract. Insurance is a method of reimbursing the patient for fees paid to the physician and not a substitute for payment. Some insurance companies pay a fixed allowance for certain procedures and others pay a percentage of the actual charge.

IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE, COINSURANCE,CO-PAYS, PRE-EXISTING OR EXCLUDED CONDITIONS NOT COVERED BY YOUR INSURANCE CARRIER. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

I understand that I am financially responsible for all charges incurred on my behalf from the date the services are rendered including any balance remaining after insurance benefits, and/or cost of attorneys fees in collecting delinquent payment (if applicable). Returned checks will incur a $30 fee. We will place a 1.5 % interest charge on the unpaid balance and assess late charges for missed payments.

I hereby authorize payment directly to Donald S. Tanner, DPM, PA of benefits to me from my insurance company otherwise payable to me. I hereby authorize the release of any medical information required by my insurance carriers. A copy of this authorization may be used in lieu of the original.

I request that authorized Medicare benefits be made on my behalf to Donald S. Tanner, DPM, PA for any services furnished to me by Dr. Donald S. Tanner. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

I request that payment of authorized Medigap benefits be made on my behalf to Donald S. Tanner DPM, PA for any services provided to me by the physicians/supplier. I authorize any holder of medical information about me to release to the above-mentioned insurance carrier any information needed to determine these benefits payable or benefits payable for related services.

HMO Disclaimer: I certify that I am not enrolled in a Health Maintenance Organization (HMO), with the exception of _____. Subsequent rejection of a claim as result of this consultation due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part.

Patient Signature: _____ Date: _____

UNIVERSITY PHYSICIANS PAVILION
7421 N. UNIVERSITY DR. • SUITE 204 • TAMARAC, FL 33321 • (954) 722-1000

DONALD S. TANNER, D.P.M., F.A.C.F.A.S.

DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY
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"Under Florida law, physicians are generallly required to carry medical malpractice insurance or otherwise demonstrate financial resposibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

_____ _____

Patient Date

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