



Dr. Paul A. Weiner
Podiatric Medicine and Surgery

15300 Jog Road, Suite 204
 Delray Beach, FL 33446
 Phone: 561 265-5424
 Fax: 561 265-5418

PATIENT REGISTRATION FORM

Name: _____

Local Address: _____

Address (City, State, Zip): _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Medical Doctor: _____ PCP's Phone #: _____

Past Medical History: _____

Past Surgical History: _____

Nature of Foot Problem: _____

Emergency Contact/Relationship: _____ Phone#: _____

Snowbird? No Yes In Florida from: Beg Middle End
 To: Beg Middle End

Alternate Address: _____ Phone: _____

Condition	Y	N	Condition	Y	N
Diabetes Endocrinologist _____ Phone # _____			Blood Condition (Phlebitis, Clotting Disorder, Gout)		
Mitral Valve Prolapse			Tobacco Use ___ packs/ day ___ Quit ___ Years ago		
Murmur			Alcohol Use ___ Rarely ___ Moderately ___ Daily		
Heart Ailment			Hypertension		

Height: _____ Weight: _____ Blood Pressure: _____

Medications: _____

Drug Allergies: _____

Pharmacy: _____ Phone #: _____

Signature: _____



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ASSIGNMENT OF BENEFITS

Assignment of Benefits:

I, the undersigned, certify that I have insurance coverage with _____, and assign directly to Weiner Podiatry, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Paul A. Weiner to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all submissions.

Signature: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- 1) Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- 2) Obtain payment from third party payers.
- 3) Conduct normal healthcare operations such as quality assessments, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, and if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____

Office Use Only: I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, and was unable to do so as documented below.

Date: _____ Initials: _____