JOSEPH C. TAUB, DPM PA
3515 SE Willoughby Blvd
Stuart, FL 34994
www.drtaubfootandwound.com
(772) 283-3800

Welcome to Our Practice!

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at 772-283-7046 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust you place in your physician. We want to provide you with the most up to date information and treatment options regarding your healthcare. We do appreciate and value the trust you have placed in us.

Joseph C. Taub, DPM PA specializes in treatment of all foot, ankle and leg disorders. Dr. Taub, a board-certified doctor, and trained office staff work together to meet your podiatric needs five days a week. We desire to assist you in receiving the best of what todayôs medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We assure you, we will do our best to meet and exceed your expectations.

We value highly the relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because it helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay** or **Deductible** is collected at the time of visit
- **Noncovered procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License or State Issued Photo ID**

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First Name:_____ MI:____ Last Name:_____

Gender: ___Female ___Male DOB:_____ Age:_____ SSN:_____

Home Address:_____ City:_____

State:_____ Zip:_____ Home #:_____ Cell #:_____

Preferred Language: __English __Spanish __French __Italian Other(Specify) _____

Race: __Native American __African American __Asian __White __Hispanic

__Pacific Islander __Other __Unreported/Refused

Referral Source __Family/Friend __Insurance Plan __Internet __Social Media

__Physician __Yellow Pages Other(Specify) _____

Primary Physician:_____ Date Last Seen:_____

Emergency Contact:_____ Phone Number:_____

Marital Status: __Single __Married __Divorced __Widowed __Life Partner

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Insurance Information *(It is the patient's responsibility to get any referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered).*

Primary Insurance:_____ Policy #:_____

Primary Insurance Policy Holder:_____ Referral Required: ___Yes ___No

Responsible Party, if different from patient information:

Name:_____ Relationship to Patient:_____ DOB:_____

Secondary Insurance:_____ Policy #:_____

Secondary Insurance Policy Holder:_____ Referral Required: ___Yes ___No

Patient or Responsible Party Signature of Agreement _____ Date _____

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Patient History

Patient Name:_____

Height:_____ Weight:_____ Shoe Size:_____ Occupation:_____

My reason for visit is:_____ Duration:_____

Nature of my problem: ___Sharp ___Dull ___Ache ___Burning ___Other:_____

Reason for onset:_____

Was condition treated by a Doctor? ___Yes ___No Doctor Name:_____

Any foot surgeries? ___Yes ___No When:_____ Where:_____

Diabetic: ___Yes ___No Average sugar:_____ Date of last checkup:_____

Insulin Dependent: ___Yes ___No Oral Medication: ___Yes ___No Diet control: ___Yes ___No

Doctor seen for diabetes:_____ Office number:_____

Check any known conditions you have, or had previously:

Anemia	Bunions	Gout	Kidney Problems
Arthritis	Bursitis	Hepatitis	Liver Disease
Artificial Joints/Valves	Cancer	Heart Problems	Muscular Disorders
Asthma	Circulation	High Blood Pressure	Swelling
Bleeding Disorder	Difficulty	High Cholesterol	Ulcers
Blood Disease	Epilepsy	HIV/AIDS	Weakness

List any other medical problems here:

Please provide a list of any known allergies:

Please provide a list of all current medications you are taking:

Please List any Major Surgeries here:

Are you up to Date with Immunizations: _____Yes _____No

Have you had the Flu Shot this year: _____Yes _____No

Have you received the Pneumonia Vaccine: _____Yes _____No

Family History

Mother: ____Alive ____Deceased
List her health conditions:

Father: ____Alive ____Deceased
List his health conditions:

Please list any other information that you may feel necessary for us to know:

Social History

Do you use tobacco? ___Yes ___No Amount:_____ How Long:_____

Previous tobacco user? ___Yes ___No How Long:_____ Quit Date:_____

Do you drink alcohol? ___Yes ___No Amount:_____

If you would like to receive our newsletter please provide your email address below:

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Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to your pharmacy.

_____
Signature

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance. We accept payment in the form of cash, check, and all major credit cards.

*Patient financial responsibilities that remain unpaid could be sent to Collections if past 90 days.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Joseph C. Taub, DPM PA when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Joseph C. Taub, DPM PA for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____
Signature

Privacy Practices (HIPAA)

By signing below, I authorize Joseph C. Taub, DPM PA, and whoever may be employed or assistant in administration to administer care as is deemed necessary.

_____
Signature

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Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave DETAILED information related to appointments, billing, test results, diagnosis, and procedures on your voicemail.

Primary Phone:_____ Secondary Phone:_____

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information regarding your appointment, billing, test results, diagnosis, and procedures in an email.

E-mail address:_____

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.
I authorize this facility to speak to the following family members or my personal representative regarding

____All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

____Only the following types of information:_____

The above medical information shall only be released to the following person(s):

1._____ Relationship:_____ Phone number:_____

2._____ Relationship:_____ Phone number:_____

3._____ Relationship:_____ Phone number:_____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time.

Name (PRINTED) _____

Signature _____

Date _____