# New Patient Intake Packet

Registration, contact, and insurance.

## Patient Registration

**First name**

**Middle**

**Last name**

**Preferred name**

**Date of birth**

**Age**

**Sex** M F

**Address**

**Apt/Unit**

**City**

**State**

**ZIP**

**Mobile**

**Email**

**Occupation**

## Emergency Contact & PCP

**Emergency contact**

**Relationship**

**Phone**

**Primary care physician**

**PCP phone**

## Insurance

**Primary insurance**

**Member ID**

**Group #**

**Subscriber**

**Subscriber DOB**

**Relationship**

**Secondary insurance**

**Member ID**

**Group #**

Responsible party same as patient

**Responsible party / guarantor**

# Medical History, Medications & Allergies

Relevant medical and social history on one page.

## Medical Conditions

- [ ] Diabetes
- [ ] High blood pressure
- [ ] Heart disease
- [ ] High cholesterol
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Bleeding / clotting
- [ ] DVT / PE
- [ ] Cancer
- [ ] Arthritis
- [ ] Gout
- [ ] Neuropathy
- [ ] Peripheral vascular
- [ ] Autoimmune
- [ ] Asthma / COPD
- [ ] Sleep apnea
- [ ] Seizure disorder
- [ ] Thyroid disease
- [ ] Osteoporosis
- [ ] Other

**Other conditions / details**

## Surgical / Hospitalization History

## Medications & Allergies

- [ ] No known drug allergies

**Allergies / reaction**

**Current medications (name, dose, frequency)**

## Safety & Social History

- [ ] Blood thinner
- [ ] Pacemaker / device
- [ ] May be pregnant
- [ ] Local anesthetic reaction
- [ ] Never smoked
- [ ] Former smoker
- [ ] Smoke / vape
- [ ] No alcohol
- [ ] Alcohol occasionally
- [ ] Alcohol regularly

**Exercise / sports**

**Standing / walking demands at work**

# Foot & Ankle History + Consents

Reason for visit, symptoms, and core acknowledgments.

## Main Concern

**Primary foot/ankle problem or reason for visit**

**Side**

**When did it begin?**

**Injury date**

**Pain 0-10**

**How did it start / injury mechanism**

## Symptoms

- Pain
- Swelling
- Bruising
- Tingling
- Weakness
- Instability
- Limited motion
- Skin/nail
- Difficulty walking
- Other

**Prior treatment / imaging / therapy / orthotics / surgery / medications**

**Main goal for this visit**

## Consent, Communication & Financial Responsibility

I voluntarily consent to evaluation and medically appropriate treatment by Dr. Carlos A. Rojas, DPM and authorized staff. No guarantee has been made regarding diagnosis, outcome, recovery, or response. Specific procedures may require separate informed consent.

- Text
- Email
- Voicemail

I authorize release of information reasonably necessary to process claims and direct payment of benefits when permitted by my plan. Insurance verification is not a guarantee of payment. I am responsible for copayments, deductibles, coinsurance, non-covered services, and balances permitted by law and contract.

I acknowledge that I received or was offered the Notice of Privacy Practices. I certify that the information provided is true and complete to the best of my knowledge.

- I acknowledge and accept the terms above.

**Patient / representative signature**

**Date**

# Privacy & Patient Notices

HIPAA, professional liability notice, rights, and responsibilities on one page.

## Notice of Privacy Practices (HIPAA)

### Your Rights

- Get a copy of your record and ask us to correct inaccurate or incomplete information.
- Request confidential communications and certain limits on uses or disclosures.
- If you pay in full out of pocket, ask us not to send that information to your health plan for payment or operations unless required by law.
- Request an accounting of certain disclosures, a paper copy of this Notice, and file complaints without retaliation.

### Uses / Responsibilities

- We may use or disclose information for treatment, payment, and health care operations.
- We may disclose when permitted or required by law, including public health, safety, oversight, legal proceedings, workers' compensation, and certain government functions.
- We must maintain privacy and security, notify affected individuals of breaches when required, and follow the Notice currently in effect.
- Florida law protects patient-record confidentiality; records protected by 42 CFR Part 2 receive additional protections.

Privacy Contact: Dr. Carlos A. Rojas, DPM / Privacy Officer, (786) 464-9991. You may also file a complaint with HHS OCR; the practice will not retaliate.

## Professional Liability Insurance Notice

### Dr. Carlos A. Rojas, DPM does not carry professional liability (medical malpractice) insurance.

☐ I acknowledge that I have been informed of this notice.

**Patient name** | **Date of birth** | **Date**

**Patient / representative signature**

## Patient Rights & Responsibilities

### Rights

- Considerate and respectful care.
- Appropriate information about diagnosis, proposed treatment, alternatives, risks, and expected outcomes.
- Participate in decisions and refuse treatment to the extent permitted by law.
- Confidential handling of records and access to copies.
- Information about charges and the ability to raise concerns without retaliation.

### Responsibilities

- Provide complete and accurate health, medication, allergy, and insurance information.
- Ask questions when you do not understand your condition, plan, instructions, or financial responsibility.
- Follow agreed treatment plans and tell us when you cannot.
- Keep appointments or provide reasonable notice when canceling/rescheduling.
- Treat staff and patients respectfully and meet permitted financial obligations.

## Preferred Pharmacy

**Pharmacy name** | **Phone** | **Address / cross streets**