

Florida Biomechanics Group
7730 Starkey Road
Seminole, FL 33777
(727)-399-1782



Florida BioMechanics Group Mission Statement

At Florida BioMechanics Group we are committed to getting you back on your feet free of pain and injury so that you can get back to your activities and back into life! We understand that when your feet hurt you hurt all over and you stop doing the things you love to do. We stop the pain and prevent the injuries that occur in people's feet, ankles, legs, knees, hips and backs by addressing the imbalances which most often begin in the feet! We feel your feet are your foundation and a strong foundation is our goal. We thank you for the opportunity to serve you and give you the results you are looking for.

Sincerely,
Dr. Bob Levine

Mr. Dr. _____ Today's Date: _____
Mrs. _____
Miss. Last Name First Name MI. Age: _____ Birthday: _____
Local Address: _____ Home Phone #: (____) _____
City: _____ State: _____ Zip: _____ Cell Phone #: (____) _____
Social Security #: _____ Sex: M / F Marital Status: S M W D E-mail address _____
I live here _____ months of the year, usually from _____ to _____ or Just Visiting
Other Address (if any): _____ Phone: (____) _____
Occupation: _____ If retired, your former occupation: _____
Patient's Employer: _____ Business Phone: (____) _____
Spouse: _____ Are they our patient? Yes / No
Are any of your friends, relatives or associates our patient? Yes / No If Yes, who? _____
If under 18 y/o, name of parent/guardian: _____ Relationship to Patient: _____
Responsible parties DOB: _____ - _____ - _____ Responsible parties SS#: _____ - _____ - _____
Whom may we thank for your referral? _____
How did you here about our practice? _____
If you used the internet to find us what search terms were used? _____

Emergency Notification

In case of emergency, notify: _____ Relationship: _____
Home Phone: (____) _____ Business Phone: (____) _____ Other: (____) _____

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Patient Name: _____

1. Do you have any FOOT pain? Yes No Right Left Both
If yes, Please explain: _____

For How long? _____

Previous treatment for this pain / problem? Yes No
If yes, Please explain: _____

Does anything make it better or worse? _____

2. Do you have any KNEE pain? Yes No Right Left Both
If yes, Please explain: _____

For How long? _____

Previous treatment for this problem? _____ Yes No
Please explain: _____

Does anything make it better or worse? _____

3. Do you have any HIP pain? Yes No Right Left Both
If yes, Please explain: _____

For How long? _____

Previous treatment for this problem? _____ Yes No
If yes, Please explain: _____

Does anything make it better or worse? _____

4. Do you have any Back pain? Yes No Upper Back Lower Back Neck
If yes, Please explain: _____

For How long? _____

Previous treatment for this problem? _____ Yes No
If yes, Please explain: _____

Does anything make it better or worse? _____

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Patient Name: _____

5. Do you have any leg cramps or pain? Yes No / Right Left Both

If yes, Please explain: (include Frequency) _____

How long has this been going on? _____

Previous treatment for this problem? _____ Yes No

If yes, Please explain: _____

Does anything make it better or worse? _____

6. Do any of the above problems limit your ability

to walk? Yes No _____

to stand? Yes No _____

to wear shoes? Yes No _____

to work? Yes No _____

to partake in social or sporting activities? Yes No _____

7. Do you currently wear or have you ever worn Orthotics (arch supports)? Yes No

If yes, were they prescribed to you by a physician or health care provider Yes No

If yes, were they the over the counter style bought from a store Yes No

If yes, did you find that they helped you to any significant degree Yes No

8. If you are a runner or athlete please tell us about your sport. Include recent history, weekly mileage breakdown, frequency or times and if you are currently training for any event.

9. What type of Shoes do you wear and how often do you wear them? Please Circle or cross out

MALE

Sneakers / Tennis Shoes _____ % of time

Lace Up Dress Shoes _____ % of time

Loafers or Deck Shoes _____ % of time

Work Boots or Other Boots _____ % of time

Flip Flops or Sandals _____ % of time

FEMALE

Sneakers / Tennis Shoes _____ % of time

Casual Shoes _____ % of time

Pumps or Low Heel Open Shoes _____ % of time

High Heel Shoes (2 inch or greater) _____ % of time

Work Boots or Other Boots _____ % of time

Flip Flops or Sandals _____ % of time

10. When you're at home, what is on your feet?

Regular Shoes _____ % of time Slippers _____ % of time Bare Feet _____ % of time

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Patient Name: _____

This is the most important part of this paper work.

11. In the last few months has there been a recent change in your:

Weight Work Activity Shoe Gear Flooring at work or home

Please explain: _____

Please tell us what are your Goals and Expectations are relating to your problem:

Relating to your specific complaint(s), what would you like to accomplish **during your visit today?** _____

Relating to your specific complaint(s), what would you like to be able to accomplish **in the near future** that you may not be able to do right at this moment? (**please include intermediate and long term goals**) _____

I understand that any follow-up appointments I make are crucial to my treatment and the success of my care. During these appointments, the Doctor will give you the necessary attention. Please have the courtesy of keeping all appointments or calling to change an appointment with 24 hours notice.

Patient/ Guardian Print: _____ Date: _____
Patient/ Guardian Signature: _____ Date: _____

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Insurance Information / Consent / Authorization

Please bring your insurance cards and a photo ID to the front desk so we may make photocopies.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediary or carriers, or to the billing agent of Florida Biomechanics Group, any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I authorize the release of my medical records to and /or from my physician or other health care providers.

I understand that payment is due at the time of service unless other arrangements have been made I also understand that when payment becomes my responsibility after 60 days, I may be charged an interest rate of 18% or 1.5% of the outstanding balance. I understand that I will be charged a fee of \$40.00, for any appointments missed with less than 24 hours cancellation notice.

Patient / Guardian Print: _____ Date: _____

Patient / Guardian Signature: _____ Date: _____

Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to: Florida Biomechanics Group for any service furnished me by the physician.

Patient / Responsible Party Print: _____ Date: _____

Patient / Responsible Party Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the Notice of Privacy Practices and that I have read, had the opportunity to read, or plan to take it home to review. It is my understanding that if I have a question, I may contact the privacy officer at Florida BioMechanics Group.

Patient Name (please print)

Date

Parent or Guardian (if applicable) (please print)

Signature