STELLAR FOOT AND ANKLE SPECIALISTS LLC

NEW PATIENT PACKET

PATIENT INFORMATION & MEDICAL HISTORY

PATIENT INFORMATION

Patient name | Date of birth | Today's date

Street address | City | State

ZIP code | Phone | Email

Primary care provider | Preferred language | Marital status

Insurance | Member / ID number | Pharmacy / phone

Emergency contact | Relationship | Emergency contact phone

Height | Weight | Race / ethnicity (optional)

MEDICAL HISTORY — CHECK ALL THAT APPLY

- ☐ None
- ☐ Asthma
- ☐ Cerebrovascular accident / stroke
- ☐ Depression
- ☐ End-stage renal disease
- ☐ Hearing loss
- ☐ Hyperthyroidism
- ☐ Breast cancer
- ☐ Lung cancer
- ☐ Bone marrow transplant
- ☐ Anxiety disorder
- ☐ Atrial fibrillation
- ☐ COPD
- ☐ Diabetes
- ☐ Epilepsy
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Colon cancer
- ☐ Leukemia
- ☐ Radiation therapy
- ☐ Arthritis
- ☐ Benign prostatic hyperplasia
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ GERD / reflux
- ☐ High cholesterol
- ☐ Hepatitis
- ☐ Prostate cancer
- ☐ Lymphoma
- ☐ Other

FOOT / ANKLE CONDITIONS — CHECK ALL THAT APPLY

- ☐ None
- ☐ Amputation
- ☐ Chronic pain
- ☐ Foreign body
- ☐ Bunion / hallux valgus
- ☐ Soft-tissue neoplasm
- ☐ Peripheral nerve disease
- ☐ Gout
- ☐ Achilles tendon rupture
- ☐ Other
- ☐ Acquired cavus foot
- ☐ Ankle ulcer
- ☐ Deep vein thrombosis
- ☐ Fracture
- ☐ Laceration
- ☐ Foot neuroma
- ☐ Peripheral vascular disease
- ☐ Recurrent falls
- ☐ Ankle sprain
- ☐ Flatfoot / pes planus
- ☐ Bone tumor
- ☐ Nail disorder
- ☐ Gangrene
- ☐ Localized infection
- ☐ Osteoarthritis
- ☐ Plantar fasciitis
- ☐ Rheumatoid arthritis
- ☐ Foot ulcer

SURGICAL HISTORY, MEDICATIONS & SOCIAL HISTORY

SURGICAL HISTORY — CHECK ALL THAT APPLY

- ☐ None
- ☐ Colectomy
- ☐ Pancreatectomy
- ☐ Coronary artery bypass
- ☐ Splenectomy
- ☐ Hysterectomy
- ☐ Low anterior resection of rectum
- ☐ Tubal ligation
- ☐ Liver transplant
- ☐ Hip replacement (left / right)
- ☐ Appendectomy
- ☐ Kidney stone procedure
- ☐ Prostatectomy
- ☐ PTCA / angioplasty
- ☐ Kidney transplant
- ☐ Nephrectomy
- ☐ Colostomy
- ☐ Oophorectomy
- ☐ Heart transplant
- ☐ Other
- ☐ Gallbladder removal
- ☐ Liver excision
- ☐ Heart valve replacement
- ☐ Cystectomy
- ☐ Skin biopsy / skin cancer excision
- ☐ Orchiectomy
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Knee replacement (left / right)

FOOT / ANKLE SURGERY — CHECK ALL THAT APPLY

- ☐ None
- ☐ Right foot amputation
- ☐ Ankle arthrodesis
- ☐ Wart cryotherapy
- ☐ Peripheral neuroma excision
- ☐ Hammertoe surgery
- ☐ Metatarsal osteotomy
- ☐ Sesamoid fracture reduction
- ☐ Flatfoot reconstruction
- ☐ Amputation
- ☐ Below-knee amputation (left / right)
- ☐ Foot arthrodesis
- ☐ Tarsal tunnel decompression
- ☐ Subcutaneous tumor excision
- ☐ Incision and drainage
- ☐ Nail procedure
- ☐ Foreign body removal
- ☐ Other
- ☐ Left foot amputation
- ☐ Above-knee amputation (left / right)
- ☐ Ankle arthroscopy
- ☐ Accessory navicular excision
- ☐ Foot fasciotomy
- ☐ Tendon lengthening
- ☐ Open fracture reduction
- ☐ Bunion repair

CURRENT MEDICATIONS

List all prescription medicines, over-the-counter medicines, vitamins, and supplements.

Medication	Dose	How often	Notes

ADDITIONAL MEDICAL & SOCIAL HISTORY

Do you take antibiotics before dental work or surgery? ☐ Yes ☐ No

Do you take blood thinners? ☐ Yes ☐ No If yes, medication: _____

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No Most recent A1C: _____ Blood sugar: _____

Medication allergies: _____ Reaction: _____

Smoking status: ☐ Every day ☐ Some days ☐ Former smoker ☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No If yes: ☐ Less than 1 drink/day ☐ 1–2/day ☐ 3+/day

In the past year, how many times have you had 5 or more drinks in one day? _____

Vaccines received: ☐ Flu ☐ Shingles ☐ Pneumonia ☐ HPV ☐ None of these

ADVANCE CARE PLANNING & VASCULAR DISEASE SURVEY

ADVANCE CARE PLANNING (PATIENTS OVER AGE 65)

Do you have a health care proxy if you are unable to make your own medical decisions? ☐ Yes ☐ No

Health care proxy / designee name

Phone number

Do you have a living will? ☐ Yes ☐ No

Please indicate your preferences. These selections are for documenting your stated wishes and do not replace formal advance directives.

☐ Do Not Intubate (DNI): I do not wish to have a breathing tube, even if needed to save my life.

☐ Do Not Resuscitate (DNR): I do not wish to have CPR or defibrillation if my heart stops.

☐ Full resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Patient / authorized representative signature

Date

VASCULAR DISEASE SURVEY

1. Do you experience pain in your legs or feet while at rest?	☐ Yes	☐ No
2. Do you have aching, fatigue, tingling, cramping, or pain in your feet, calves, buttocks, hips, or thighs during exercise?	☐ Yes	☐ No
3. If yes to question 2, does the pain go away when you stop walking or exercising?	☐ Yes	☐ No
4. Do your feet ever become pale, discolored, or bluish?	☐ Yes	☐ No
5. Have you had an infection, skin wound, or ulcer on your leg or foot that healed slowly over 8–12 weeks?	☐ Yes	☐ No
6. Are you 65 years of age or older?	☐ Yes	☐ No
7. Are you 50 years of age or older?	☐ Yes	☐ No
8. Do you have high cholesterol or take medication to lower cholesterol?	☐ Yes	☐ No
9. Do you have high blood pressure or take medication to lower it?	☐ Yes	☐ No
10. Do you have diabetes?	☐ Yes	☐ No
11. Do you have chronic kidney disease?	☐ Yes	☐ No
12. Do you currently smoke or have you ever smoked?	☐ Yes	☐ No
13. Have you had a stroke or mini-stroke (TIA)?	☐ Yes	☐ No
14. Have you had heart disease, including a heart attack?	☐ Yes	☐ No
15. Have you had carotid stenosis, an abdominal aortic aneurysm, or a stent placed?	☐ Yes	☐ No

FINANCIAL POLICY & PATIENT ACKNOWLEDGMENT

WELCOME

Stellar Foot And Ankle Specialists LLC welcomes you to our practice. We strive to provide excellent medical care and make your visits as pleasant as possible. Please review the following policies.

FINANCIAL POLICY

- It is your responsibility to notify our office of any changes to your address or telephone number.
- Our billing service may send statements for accounts with outstanding balances to the mailing address on file.
- All applicable self-pay amounts, copayments, coinsurance, and deductibles are due at the time of service unless other arrangements have been approved.
- Payments may be made by cash, check, Visa, Mastercard, or Discover.
- The office may charge a $20 fee for appointments canceled or missed without at least 24 hours' notice.

INSURANCE & PAYMENT RESPONSIBILITY

We will submit claims to your health insurance plan as a courtesy when applicable. Our relationship is with you, the patient, rather than your insurance company. Please understand:

- Not all services are covered benefits under every insurance plan.
- You are responsible for understanding your coverage and whether the services provided are covered benefits.
- You are responsible for charges not paid by your insurance, including non-covered services and applicable patient balances.
- We generally bill primary and secondary insurance plans; we do not bill every third-party payer.
- Submitting claims is a courtesy. Financial responsibility remains with you from the date services are provided.

I understand that I am financially responsible for charges related to services provided, whether or not insurance pays. I authorize Stellar Foot And Ankle Specialists LLC to release information necessary to process insurance claims and request payment of benefits, and I authorize use of my signature on insurance submissions where permitted.

Patient signature

Responsible party (if applicable)

Date

PRIVACY ACKNOWLEDGMENT & HIPAA DISCLOSURE AUTHORIZATION

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided access to a copy of the Notice of Privacy Practices and have had the opportunity to read and understand it.

Patient name

Patient signature

Date

Parent or authorized representative (if applicable)

Relationship

HIPAA AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of birth: _____

I authorize Stellar Foot And Ankle Specialists LLC to disclose my health information, which may include appointment information, laboratory or imaging results, diagnoses, treatments, medications, and surgical information, to the individuals listed below by mail, telephone, fax, or email, as appropriate.

Name	Date of birth	Relationship	Phone

I understand that this authorization is voluntary and may be revoked in writing, except to the extent action has already been taken in reliance on it. This authorization does not permit disclosure prohibited by law.

Patient / authorized representative signature

Date

CONSENT FOR AI AMBIENT LISTENING DURING PATIENT VISITS

PLEASE READ BEFORE SIGNING

Stellar Foot And Ankle Specialists LLC may use an artificial intelligence (AI)-enabled ambient listening tool during your visit to help create clinical documentation. If you consent, the tool may listen to the conversation between you and your healthcare provider and generate a draft note or summary for your medical record.

The AI tool is intended to assist with documentation only. Your healthcare provider remains responsible for reviewing and editing the draft for accuracy. The tool does not independently diagnose or determine your treatment.

Depending on the technology used, audio and/or conversation data may be processed by a service provider to generate the draft documentation. The practice will use the tool in accordance with its privacy and security procedures and applicable law. Please ask the practice if you would like more information about the specific technology, data handling, or retention practices.

Your participation is voluntary. You may decline or withdraw your consent at any time by telling your healthcare provider or office staff. Declining will not affect your ability to receive care, and the practice can document your visit without the ambient listening tool. If you withdraw consent during a visit, the tool should be turned off as soon as reasonably possible.

Please avoid sharing information you do not want processed by the ambient listening tool while it is active. You may ask questions before making your choice.

PATIENT CONSENT

Please select one:

☐ YES — I consent to the use of AI ambient listening for documentation during my visits.

☐ NO — I do not consent to the use of AI ambient listening during my visits.

Patient name (print)

Date of birth

Patient / authorized representative signature

Date

Representative name (if applicable)

Relationship to patient

Office use: Consent status recorded in the medical record. If consent is declined or withdrawn, staff should ensure the ambient listening feature is not used for that visit.

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

PROTECTING DNA PRIVACY ACT - FLORIDA STATUTES SECTION 817.5655

Protecting DNA Privacy Act Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

Throughout your course of care at DeLand Foot and Leg Center, LLC it may be medically necessary to obtain a blood, urine, stool, tissue, or other type of biological specimen for analysis. This analysis will not involve the examination of DNA to identify the presence and composition of genes in your body.

After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and transferred to a third party for disposal in accordance with all local, state, and federal requirements.

It may also be the case during a routine or surgical procedure, that biological specimens such your blood, urine, hair, or bodily fluids may be deposited on medical instruments, bedding, clothing, or other objects. These objects may be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with DeLand Foot and Leg Center, LLC to a third party as described above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

PATIENT / PARENT OR LEGAL GUARDIAN ACKNOWLEDGMENT

Patient Printed Name: _____

Patient Signature / Parent or Legal Guardian Signature for Minor Patient: _____

Date: _____