

**REGISTRATION FORM**

PLEASE PRINT

**PATIENT INFORMATION**

**DATE:** \_\_\_\_\_  
 Middle Sex:  M  F  
 Age (Edad): \_\_\_\_\_

Patient's last name (Apellido): \_\_\_\_\_ First (Nombre): \_\_\_\_\_

Birth date (Fecha de Nac.): / / Social Security No: \_\_\_\_\_  
 Home phone (Telefono): ( ) Cell (Celular): ( ) Drivers License # \_\_\_\_\_  
 Street Address (Direccion): \_\_\_\_\_ Email (Correo electronico): \_\_\_\_\_  
 City (Ciudad): \_\_\_\_\_ State (Estado): Zip Code: \_\_\_\_\_  
 Employer (Empleador): \_\_\_\_\_ Employer phone (Telefono Trab.) ( ) \_\_\_\_\_  
 Employer Address (Direccion de Empleador): \_\_\_\_\_ Dr. Phone (Telefono Del Dr.) # \_\_\_\_\_  
 Referred by (Referido por)  Dr. Name \_\_\_\_\_  
 Other family members seen here: \_\_\_\_\_  
 (Otros miembros de la familia vistos aqui): \_\_\_\_\_

**INSURANCE INFORMATION IS THIS PERSON COVERED BY INSURANCE?  YES  NO**

Primary Doctor Name (Doctor primario): \_\_\_\_\_ Phone no. (Telefono) ( ) \_\_\_\_\_ Fax no. (Telefono de fax) ( ) \_\_\_\_\_

Person responsible for bill: \_\_\_\_\_ SS# \_\_\_\_\_ Phone: \_\_\_\_\_ Address if different from above (Persona responsable de cuenta): \_\_\_\_\_ (Direccion diferente de arriba): \_\_\_\_\_  
 Birth Date (Fecha de Nac.): / / (Telefono): \_\_\_\_\_

Occupation (Ocupacion): \_\_\_\_\_ Employer (Empleador): \_\_\_\_\_ Employer address (Direccion del Empleador): \_\_\_\_\_ Employer phone (Telefono Trab.): ( ) \_\_\_\_\_

Primary Insurance (Seguro del primario): \_\_\_\_\_ Policy (Numero de politica) # \_\_\_\_\_ Group (Agrupe numero) # \_\_\_\_\_

Subscriber's name (Nombre de suscriptor): \_\_\_\_\_ Birth date (Fecha de Nac.): / / Subscriber's S.S. no.: (Numero S.S. del suscriptor): \_\_\_\_\_

Patient's relationship to subscriber: \_\_\_\_\_  Self  Spouse  Child  Other Co Payment \$ \_\_\_\_\_  
 (Relacion del paciente al suscriptor): \_\_\_\_\_

Name of secondary insurance (El nombre de seguro secundario) \_\_\_\_\_ Subscriber's name: (Nombre de suscriptor): \_\_\_\_\_ Policy (Numero de politica) # \_\_\_\_\_

Patient's relationship to subscriber: \_\_\_\_\_  Self  Spouse  Child  Other Group (Agrupe numero): # \_\_\_\_\_  
 (Relacion del paciente al suscriptor): \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name (Contacto de emergencia): \_\_\_\_\_ Relationship (Relacion): \_\_\_\_\_ Home Phone (Telefono de casa) \_\_\_\_\_ Work Phone (Telefono Trab) \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required processing my claims.

**Patient/Guardian signature**

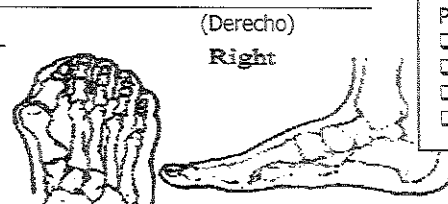
\_\_\_\_\_  
 (El paciente / Firma de guardian) Date: \_\_\_\_\_  
 (Fecha)

**CURRENT PROBLEMS LIST:**

\_\_\_\_\_  
 (Lista de los problemas actuales): \_\_\_\_\_



Please use circles and arrows to indicate painful, injured or problem area(s)



LENGTH OF TIME FOR CURRENT PROBLEM: \_\_\_\_\_  
 DAYS  
 WEEKS  
 MONTHS  
 YEARS



**PAST MEDICAL HISTORY**

**Patient Name:** \_\_\_\_\_

(Nombre del Paciente)

**Current Medications List:**

(Actual lista de medicamentos)

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Are you currently taking any of the following?**

(¿Está tomando alguna de las siguientes?)

- Echinacea    Garlic    Ginger    Gingko Biloba    St. John's Wort    Ginseng    Kava kava  
 Feverfew    Ephedra

**Allergies:**

(Alergias)

- Penicillin    Sulfa drugs    Aspirin    Codeine    Iodine/shellfish    Tape

- Local anesthetics    General anesthetics    Latex

- Other antibiotics    Non-steroidal medications    Other pain medications  
(Otros antibióticos)   (Medicamentos sin esteroides)   (Otros medicamentos para el dolor)

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medication allergies (Alergias a los medicamentos): \_\_\_\_\_

Food allergies (Alergias alimentaria): \_\_\_\_\_

Environmental allergies (Alergias ambientales): \_\_\_\_\_

**Previous Injuries:**  
(Lesiones anteriores)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Surgeries:**  
(Cirugías previas)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Hospitalizations:**  
(Hospitalizaciones previas)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

(Firma del paciente)

**Date:** \_\_\_\_\_

(Fecha)



## ILLNESSES

NAME: \_\_\_\_\_

### MAJOR DISEASE: ARTHRITIS:

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid     |
| <input type="checkbox"/> Angina       | <input type="checkbox"/> Gout           |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sero-negative: |
| <input type="checkbox"/> Arrhythmia   |   |
| <input type="checkbox"/> Murmur       |   |
| <input type="checkbox"/> Stroke       |   |
| <input type="checkbox"/> Chest Pain   |   |

### VASCULAR:

- Anemia
- Sickle Cell
- Bleeding Disorders
- Poor Conditions
- Night Cramps
- Leg Pain when Walking
- Vein Problems
- Spider Veins
- Varicose Veins
- Swelling Phlebitis
- Leg Ulcerations
- Blood Clots
- Transfusions

### HEENT:

- Headaches
- Eye Problems
- Hearing Problems

### RESPIRATORY:

- Asthma
- Bronchitis
- Frequent Colds
- Lung Disease
- Shortness of Breath
- Tuberculosis
- Emphysema

### MISCELLANEOUS:

- Epilepsy
- Thyroid Disease
- Muscle Disease
- Kidney Problems
- Bladder Problems
- Prostate Problems
- Venereal Disease
- Skin Conditions
- Cancer History
- Hepatitis

### PSYCHOLOGICAL:

- Anxiety
- Depression
- Psychiatric
- Drug Dependence
- Alcohol Dependence

### OTHER ILLNESSES:

### GASTRONINTESTINAL:

- |   |  |
|---|--|
| <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Bowel Disorders       |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> GI or Rectal Bleeding |
| <input type="checkbox"/> Hiatal Hernia    | <input type="checkbox"/> Acid Reflux (GERD)    |

### SOCIAL HISTORY:

Occupation: \_\_\_\_\_  
 Athletic Activities: \_\_\_\_\_

Single  
 Married  
 Alcohol: \_\_\_\_\_ oz/day/week  
 Tobacco: \_\_\_\_\_ pks/d for \_\_\_ yrs

### FAMILY HISTORY:

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_



DANIEL BELL DPM, PA  
*Adult and Pediatric  
Foot & Ankle Surgery  
Sports Medicine  
Wound Care*

## PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the Judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, authorize that Daniel Bell; D.P.M. will use and disclose my information for the purposes of treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to: Daniel Bell, D.P.M. of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I understand that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Broward Health Department and appropriate counseling will be offered.

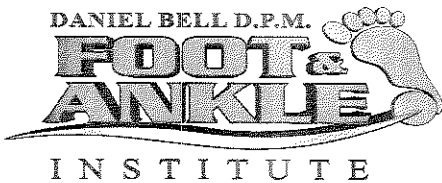
MEDICARE PATIENTS; I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Daniel Bell, D.P.M.

I acknowledge that I have been given the Dr. Bell Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Patient (or Responsible Party) Signature

\_\_\_\_\_  
Date



DANIEL BELL DPM, PA  
*Adult and Pediatric  
Foot & Ankle Surgery  
Sports Medicine  
Wound Care*

## NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

-The right to complain to this practice and to the Secretary of HHS if I believe my privacy right's have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.

-The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.

-The right to receive confidential communications of protected health information.

-The right to inspect and copy protected health information.

-The right to amend protected health information.

-The right to receive an accounting of disclosures of protected health information.

-The right to obtain a paper copy of the Notice of Privacy practices from this practice upon request.

This practice reserves the right tot change the terms of its Notice of Privacy practices and to make new provisions effective for all protected health information that is maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_

601 N. Flamingo Road, Suite 208  
Pembroke Pines, FL 33028  
(954) 942-5005  
(954) 432-9446 fax



DANIEL BELL, D.P.M., PA

THIS IS OUR OFFICE FINANCIAL POLICY PLEASE SIGN BELOW..

We at Dr. Bell's office are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. If you have no insurance or your insurance is not valid on the date of service you are personally responsible for any and all fees. We accept payment in the form of cash, check, MasterCard, or Visa. We will be happy to help you process your insurance claim at each visit.

You must realize, however that any co-payments required by your insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

1. Insurance is a contract between **YOU** and your **INSURANCE COMPANY**. If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or non payment/denial from the insurance company and you will be personally responsible for any unpaid charges. Your **INSURANCE COMPANY** states: *Benefits are based on information available at this time and are subject to coverage in effect on the date of service. This is not a guarantee of payment. Non-payment of premiums and other contractual limitations may result in denial of benefits or refunds.*
2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R.. "U.C.R." is defined as Usual, Customary and Reasonable fees for this region. Thus, our fees are considered Usual, Customary and Reasonable by most companies. This does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of fees and cost of care in this area.
3. **Not all services are a covered benefit in all contracts.** Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.
4. **MEDICARE PATIENTS:** We would like you to understand that taking **ASSIGNMENT** means that **YOU** are responsible for the **YEARLY DEDUCTIBLE OF \$162.00** and for the **20% (CO INSURANCE)** of what Medicare allows. **YOU** are also responsible for services that your co-insurance doesn't cover. **IF** your co-insurance doesn't pay this amount, **YOU** are responsible for it.

Unlike some offices, the **FILING OF INSURANCE CLAIMS** is a **COURTESY** that we have always extended to our patients. However, all charges are **YOUR** responsibility, **NOT** your Insurance Company's. We will make our **BEST EFFORT** to collect from the, but if, despite our best efforts, if we are **NOT SUCCESSFUL**, **YOU** are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have a balance on your account, we will send you a monthly statement showing charges and any payment or credits applied to your account. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** don't hesitate to ask us. **WE REALLY ARE HERE TO HELP YOU.**

I authorize payment of **MEDICAL BENEFITS** be made on my behalf to Dr. Daniel Bell, for any services furnished to me. I authorize the release of any medical information held by Dr. Daniel Bell to the health care financing administration and its agents, to process my claims.

The Financial Policy continues on the back side of this page.

\_\_\_\_\_  
Please print: Patient's name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible party if not the patient

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date



DANIEL BELL DPM, PA  
*Adult and Pediatric  
Foot & Ankle Surgery  
Sports Medicine  
Wound Care*

**THIS IS REQUIRED BY THE FEDERAL GOVERNMENT FOR YOUR  
PROTECTION AND PRIVACY**

I AUTHORIZE THE OFFICE OF DANIEL BELL DPM TO LEAVE A MESSAGE OR VOICE MAIL ON MY ANSWERING MACHINE, TELEPHONE OR CELL PHONE IN REGARDS TO MY TREATMENT, APPOINTMENT, OR SURGERY THAT IS TO BE SCHEDULED.

I DO NOT AUTHORIZE THE OFFICE OF DANIEL BELL DPM TO LEAVE A MESSAGE OR VOICE MAIL ON MY ANSWERING MACHINE, TELEPHONE OR CELL PHONE IN REGARDS TO MY TREATMENT, APPOINTMENT, OR SURGERY THAT IS TO BE SCHEDULED.

I AUTHORIZE THE STAFF OF DANIEL BELL DPM TO DISCUSS MY TREATMENT, APPOINTMENT OR SURGERY THAT IS TO BE SCHEDULED WITH THE FOLLOWING:

NAME:

RELATIONSHIP:

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PATIENT SIGNATURE

DATE

601 N. Flamingo Road  
Suite 208  
Pembroke Pines, FL 33028  
(954) 942-5005  
(954) 432-9446 fax



Notifier(s):

Patient Name:

Identification Number:

**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

**NOTE:** If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

|                                      |  |  |  |
|--------------------------------------|--|--|--|
| <b>Listed or Checked Items Only:</b> |  |  |  |
| <b>Reason Medicare May Not Pay:</b>  |  |  |  |
| <b>Estimated Cost:</b>               |  |  |  |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**Options:** Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the \_\_\_\_\_ listed above. I understand with this choice I am **not responsible for payment**, and I cannot appeal to see if Medicare would pay.

**Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

|                   |              |
|-------------------|--------------|
| <b>Signature:</b> | <b>Date:</b> |
|-------------------|--------------|

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850



# Do I Need a Test for PAD?

*Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.*

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Circle "Yes" or "No":**

|  | Test for PAD |    |                          |
|--|--------------|----|--------------------------|
| 1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? | Yes          | No | <input type="checkbox"/> |
| 2. Do you experience any pain at rest in your lower leg(s) or feet?  | Yes          | No | <input type="checkbox"/> |
| 3. Do you experience foot or toe pain that often disturbs your sleep?  | Yes          | No | <input type="checkbox"/> |
| 4. Are your toes or feet pale, discolored, or bluish?  | Yes          | No | <input type="checkbox"/> |
| 5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?  | Yes          | No | <input type="checkbox"/> |
| 6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?   | Yes          | No | <input type="checkbox"/> |
| 7. Have you suffered a severe injury to the leg(s) or feet?  | Yes          | No | <input type="checkbox"/> |
| 8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?  | Yes          | No | <input type="checkbox"/> |

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Do I Need a Test for CVI?

*Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 2.5 million Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular health status.*

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Circle "Yes" or "No":**

|   | Test for Venous Disease |    |                          |
|---|-------------------------|----|--------------------------|
| 1. Are your legs swollen, painful, red or warm to the touch?  | Yes                     | No | <input type="checkbox"/> |
| 2. Have you had a blood clot in a vein that caused inflammation, pain or irritation?  | Yes                     | No | <input type="checkbox"/> |
| 3. Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs?                                | Yes                     | No | <input type="checkbox"/> |
| 4. Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers? | Yes                     | No | <input type="checkbox"/> |
| 5. Do your legs feel heavy, tired, restless or achy?  | Yes                     | No | <input type="checkbox"/> |
| 6. If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple?                                     | Yes                     | No | <input type="checkbox"/> |
| 7. If your feet, ankles and legs are swollen, does the skin look stretched or shiny?  | Yes                     | No | <input type="checkbox"/> |
| 8. Do you have an ulcer on the inside of your ankle?  | Yes                     | No | <input type="checkbox"/> |

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_