Jenneffer Pulapaka, DPM, AACFAS
DELAND FOOT AND LEG CENTER 844 N. Stone St., Ste 208, DeLand, FL 32720
Office: 386-738-3733 | Fax: 386-738-3733 | www.DFALC.com

Patient Name :	Social Security #:
Address:	City:
	Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:
Date of Birth:	Occupation:
Ethnicity & Preferred Language:	Marital Status:
Gender Identified with:	

Insurance Information (we do not accept **ANY** Medicaid or HMO policies)

Name Primary Insurance Information:
Name Secondary Insurance Information:

Emergency Contact Information

Name:	Relationship:
Address:	City, Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:

Alternate Address

Address:	City:
	Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:

Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I want) and understand the Notice.

Please be advised that the following forms are available upon your request:

- Patient Authorization of Release Health Information
- Patient Complaint Form
- Accounting of Disclosures Form
- Request for Correction/Amendment of Health Information
- Restriction Request Form
- Request for Confidential Communication

LIFETIME SIGNATURE AUTHORIZATION AND INSURANCE PAYMENT ORDER (REQUIRED)

I authorize the release of my medical information necessary to process my claims. I also authorize any request of payment of medical benefits to DeLand Foot and Leg Center, LLC or treating physician.

Everything I have answered is true, complete, and correct to the best of my knowledge.
THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.

Patient Name (print):	Date:
Patient or Guardian's Signature:	