Jonathan R. Selbst, DPM
5175 West Atlantic Avenue, Suite F
Delray Beach, FL 33484
Tel: (561) 638-8635
Fax: (561) 638-8632

Name: _____ DOB: _____ Primary Care Doctor:_____

I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed in my paperwork.

Assignment of Benefits:
I authorize payment of medical benefits to Florida Foot & Ankle Care, LLC.

Release of Information:
I authorize the release of any medical information necessary to process this claim.

HIPAA Privacy:
I acknowledge that I received my HIPAA Privacy Practices Notice.

Medication History:
I authorize the doctor's office to retrieve my medication history.

Additional Questions:

Did you receive the flu shot this past year?	Yes	No	
Did you receive your pneumococcal vaccine?	Yes	No	
Have you fallen in the last 12 months?	Yes	No	
If yes, were you injured from this fall?	Yes	No	N/A

Advanced Directives:
Do you have the following in place?

Living Will	Yes	No
DNR	Yes	No
Durable Power of Attorney	Yes	No
Surrogate Appointed	Yes	No
None of the Above	☐	

Smoking: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Consent to Treatment: I hereby authorize Dr. Jonathan Selbst, DPM to administer treatment on the above-named patient as he deems necessary.

_____ _____ _____
Patient/Authorized Signature Printed Name Date

*****Please email this completed form to DelrayFoot@gmail.com or fax to 561-638-8632*****