

<p>NAME: First _____ Middle _____ Last _____</p> <p>_____</p> <p>Mailing Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Primary Phone _____ OK to leave message? Y N</p> <p>Secondary Phone _____ OK to leave message? Y N</p> <p>Emergency Contact Name _____</p> <p>Emergency Contact Phone _____</p> <p>E-mail Address _____</p>	<p>Date of Birth _____ Sex: M F</p> <p>Social Security Number _____ (required by most insurance)</p> <p>Marital Status: S M D W</p> <p>Employer/Occupation _____</p> <p>Spouse Employer _____</p> <p>Responsible Party _____ (other than self/spouse)</p> <p>Referred by _____</p> <p>Primary Doctor _____</p> <p>Primary Doctor Phone _____</p>
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INSURANCE INFORMATION

<p>Primary Insurance _____</p> <p>Policy Holder _____</p> <p>Subscriber ID Number _____</p> <p>Group Number _____</p> <p>Provider Cust. Svc. Phone No. _____</p>	<p>Secondary Insurance _____</p> <p>Policy Holder _____</p> <p>Subscriber ID Number _____</p> <p>Group Number _____</p> <p>Provider Cust. Svc. Phone No. _____</p>
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MEDICAL HISTORY (list illness/surgery and dates)

<p>HOSPITALIZATIONS</p> <p>OR</p> <p>PREVIOUS MAJOR</p> <p>SURGERIES?</p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p>ARE YOU PREGNANT?</p> <p align="center">Y N</p>	

<p><u>FAMILY HISTORY</u> HAS ANY RELATIVE HAD THE FOLLOWING:</p> <p><input type="checkbox"/> ARTHRITIS _____</p> <p><input type="checkbox"/> CANCER _____ TYPE: _____</p> <p><input type="checkbox"/> HEART DISEASE _____</p> <p><input type="checkbox"/> HYPERTENSION _____ (HIGH BLOOD PRESSURE)</p> <p><input type="checkbox"/> DIABETES _____ TYPE I OR II ?</p>	<p align="center"><u>SOCIAL HISTORY</u></p> <p>ALCOHOL: Y N SMOKING: Y N EXERCISE: Y N</p> <p>Drinks per day _____ Packs per day _____ Type _____</p> <p>Drinks per week _____ No. of Years _____ How often? _____</p> <p>Alcohol Problem? _____ Year Stopped _____</p> <p align="center">Y N <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar</p> <p align="center"> <input type="checkbox"/> Chew <input type="checkbox"/> Cigarette</p> <p align="center">HISTORY OF DRUG USE?</p> <p align="center">Y N</p>
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For Office Use Only BP _____ Pulse _____ Temperature _____	Height _____ Weight _____ Shoe Size _____	Patient Preferences Family Doctor _____ Preferred Pharmacy/Location _____																		
DRUG ALLERGIES AND REACTIONS: _____ _____ _____ _____ _____		PLEASE LIST CURRENT MEDICATIONS AND DOSAGE (INCLUDE VITAMINS & HERBAL SUPPLEMENTS): <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Medication Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Dosage</th> <th style="text-align: left; border-bottom: 1px solid black;">Used to Treat:</th> </tr> </thead> <tbody> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> </tbody> </table>	Medication Name	Dosage	Used to Treat:															
Medication Name	Dosage	Used to Treat:																		
LATEX ALLERGY? Y N		List any additional on the back of form, or attach list.																		

Briefly describe your foot problems and concerns:

Check all symptoms that you CURRENTLY have:

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Easily Fatigued | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Elevated blood sugar |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Cough | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Unusual weight gain |
| <input type="checkbox"/> Malaise | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Unusual weight loss |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Abnormal bruising |
| <input type="checkbox"/> Recent eye exam | <input type="checkbox"/> Dementia | <input type="checkbox"/> Ankle sprains | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Slow healing |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Peripheral neuropathy | <input type="checkbox"/> Taking blood thinner |
| <input type="checkbox"/> Edema | Type _____ | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Weakness | |

History of illnesses:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> COPD | <input type="checkbox"/> Gout | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Ankle sprains | <input type="checkbox"/> Degenerative arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> PVD/poor circulation |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Reduced liver function |
| <input type="checkbox"/> Asthma | Type I or II? _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> DVT/blood clot | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy/seizures/fainting | <input type="checkbox"/> Hypothyroid | Type _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung problem | <input type="checkbox"/> Stomach ulcers |
| Type _____ | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> GERD/gastric reflux | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tuberculosis exposure |

CONSENT TO TREAT

I hereby give my permission to be examined and initiate treatment of my feet and/or ankles.

Patient Signature _____ Date _____

FINANCIAL POLICY

1. You are responsible for payment of the services you receive in our office. Please understand that your medical insurance is a contract between you and your insurance company and that you are ultimately responsible for any unpaid balance.
2. We accept payment in cash, check, Visa and Mastercard. There is a \$25 fee on returned checks.
3. If you have insurance coverage, please give your identification cards and necessary forms to the office assistant. We will gladly bill your insurance directly. If you have no insurance coverage or choose to bill your insurance company yourself, payment is due at the time of service.
4. Co-payments are due at the time of service. There is a \$10 billing fee for co-payments not paid on the date of service.
5. Late cancellations (less than 24 hours notice) or No-Shows will be charged a \$25 fee. This is not billable to your insurance, and is your financial responsibility. Payment of this fee is required prior to the next office visit. After three No-Shows, you may be dismissed from the practice.

Our office sends out monthly statements. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance on your account. You are responsible for any balance due and coordination of payment with your insurance company. There is a \$10 re-billing fee for all unpaid balances over 60 days at each statement date. You will be responsible for any attorney or court costs due to collections.

I have read and understand the above financial conditions and I agree to the requirements as stated.

Patient Signature _____ Date _____
(Or parent/guardian)

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient Name _____ Date _____

Patient Signature _____

Relationship to Patient _____

RELEASE OF INFORMATION

I hereby authorize Pacific Podiatry Group to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other healthcare operations. My protected information may be released to the following individuals:

Name _____ DOB _____ Relationship to Patient _____

Name _____ DOB _____ Relationship to Patient _____

If this information is not completely filled out, Pacific Podiatry Group will not release information to anyone listed above.

Patient Signature _____ Date _____