PACIFIC PODIATRY GROUP

Foot & Ankle Care | Surgical Disciplines

Patient Information:

First Name: _____

Middle Initial: _____

Last Name: _____

DOB: _____ Sex: ☐M ☐F

Please indicate your race:

☐American Indian or Alaskan Native

☐White/Caucasian

☐Asian

☐Black/African American

☐Pacific Islander

☐Other

☐Declined

Please indicate your ethnicity:

☐Hispanic or Latino

☐Not Hispanic or Latino

Please indicate your preferred language:

☐English

☐Spanish

☐Korean

☐Vietnamese

☐German

Social Security #: _____

Address: _____

City: _____

State: _____ Zip: _____

Marital Status:

☐Single ☐Married ☐Divorced ☐Widowed

Employment Status:

☐Employed ☐Retired ☐Disabled

☐Unemployed ☐Student

Employer Name: _____

Occupation: _____

Patient Home Phone: _____

Patient Work Phone: _____

Patient Cell Phone: _____

Email Address: _____

Emergency Contact Information:

First Name: _____

Last Name: _____

Phone Number: _____

Relationship to Patient: _____

Primary Insurance:

Insurance Company: _____

Insurance Policy Holder: _____

Relationship: _____

Policy Holder DOB: _____

Secondary Insurance:

Insurance Company: _____

Insurance Policy Holder: _____

Relationship: _____

Policy Holder DOB: _____

Patient Name (Print) _____ DOB _____

Patient Associations:

Primary Care Physician: _____

Referring Doctor: _____

Preferred Pharmacy: _____

Location: _____

Guarantor Information (if other than patient):

Relation to Patient: _____

First Name: _____

Last Name: _____

DOB: _____

Sex: ☐M ☐F

SSN: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Employer: _____

Medical History

List Hospitalizations or Previous Major Surgeries/Dates (Use back of page for more space):

_____

_____

_____

_____

_____

_____

_____

Family History

Has any relative **(NOT YOURSELF)** had the following:

☐ Arthritis _____

☐ Cancer _____

Type: _____

☐ Heart Disease _____

☐ Hypertension _____

(High BP)

☐ Diabetes (I or II) _____

Are You Pregnant?

☐ Yes ☐ No

Social History

Alcohol: Y / N

Drinks per day _____

Drinks per week _____

In Recovery: Y / N

History of Drug Use? Y / N

# of Years _____ Quit Date _____

Smoking: Circle: CURRENT / FORMER / NEVER

Packs per day _____

No. of Years _____

Year Stopped _____

☐ Pipe ☐ Cigar

☐ Chew ☐ Cigarette

Exercise: Y / N

Type _____

How Often? _____

Patient Name (Print) _____ DOB _____

Drug Allergies and Reactions:

Latex Allergy? Y / N

Current Medications/Dosages (Include Vitamins and Herbal Supplements)

Medication Name	Dosage (mg/mcg)	Used to Treat

List any additional on the back of form, or attach list.

Briefly describe your foot problems and concerns:

Height/Weight/Shoe Size

Height: _____ Weight: _____

Shoe Size: _____

FOR OFFICE USE ONLY:

BP _____ PULSE _____

TEMPERATURE _____

Patient Name (Print) _____ DOB _____

Check all symptoms you CURRENTLY have:

☐ Chills	☐ Palpitations	☐ Joint Stiffness	☐ Slow Healing	☐ Peripheral Neuropathy
☐ Fever	☐ Shortness of Breath	☐ Low Back Pain	☐ Elevated Blood Sugar	☐ Tingling
☐ Easily Fatigued	☐ Chest Pain	☐ Constipation	☐ Abnormal Bruising	☐ Numbness
☐ Weakness	☐ Wheezing	☐ Blood in Urine	☐ Taking Blood Thinner	
☐ Unusual Weight Gain	☐ Cough	☐ Blood In Stool	Type:_____	
☐ Unusual Weight Loss	☐ Ankle Sprains	☐ Diarrhea	☐ Insomnia	
☐ Dementia	☐ Joint Pain	☐ Migraines	☐ Sleep Apnea	
☐ Blurred Vision	☐ Joint Swelling	☐ Dizziness	Circle: CPAP / BiPAP	
☐ Recent Eye Exam	☐ Broken Bones	☐ Lightheadedness		
☐ Dry Skin	☐ Edema	☐ Frequent Headaches		

History of Illnesses

☐ AIDS/HIV	☐ Bronchitis	☐ Anxiety	☐ Asthma	☐ Anemia
☐ Broken Bones: Orthopedic Hardware Location(s):_____				
☐ Cancer: Type_____		☐ COPD	☐ Bleeding Disorder Type: _____	
☐ Gout	☐ Depression	☐ DVT/Blood Clot		☐ Epilepsy/Seizures
☐ Fibromyalgia	☐ Frequent Headaches	☐ GERD	☐ Gastric Reflux	☐ Heart Disease
☐ High Blood Pressure		☐ Heart Murmur	☐ Hepatitis	☐ Hypothyroid
☐ High Cholesterol		☐ Multiple Sclerosis		☐ Muscular Dystrophy
☐ PVD/Poor Circulation		☐ Stroke		☐ Stomach Ulcers
☐ Reduced Liver Function		☐ Rheumatoid Arthritis		☐ MRSA: Date_____
☐ Congestive Heart Failure		☐ Tuberculosis Exposure		☐ _____
☐ Lung Problem		☐ _____		☐ _____

History of Renal Failure: Y /N

Date Diagnosed: _____

Dialysis Y /N

Diabetes: Type I /II

# of Years: _____

Date of last A1c: _____

Result: _____

Patient Name (Print) _____ DOB _____

Consents and Acknowledgements

I. Consent to Treat

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

Patient Signature _____ Date _____

II. 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 company 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 (3) 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 rebilling 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 (or guardian) Signature _____ Date _____

III. 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 (Print) _____ Date _____

Signature _____ Relationship _____

Patient Name (Print) _____ DOB _____

Release of Information

In order to remain compliant with HIPPA laws, unless you have provided your written consent, we will not release your private health care information, nor will we acknowledge that you are a patient with our practice.

Please list the name, date of birth, and relationship of any individuals that you wish us to be able to have contact with regarding your health care.

Patient Name _____

Name	DOB	Relationship to Patient

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 above individuals. I realize that I may change this information at any given time.

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

Patient Signature_____ Date _____

Patient Name (Print) _____ DOB _____