SAN DIEGO PODIATRY GROUP

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _____ _____ _____
LAST FIRST MI

DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F WEIGHT: _____ HEIGHT:_____

HOME ADDRESS: _____

CITY/STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

RACE:_____ ETHNICITY:_____

MARITAL STATUS: _____ SPOUSE NAME: _____

OCCUPATION: _____ EMPLOYER: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

MAY WE OBTAIN YOUR PREVIOUS PRESCRIPTION/MEDICATION HISTORY THROUGH EXTERNAL SOURCES? YES NO

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?_____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO SAN DIEGO PODIATRY GROUP OR ANY SERVICES FURNISHED TO ME BY A PHYSICIAN FROM THE GROUP. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS FOR RELATED SERVICES. IF THE PHYSICIAN IS A PARTICIPATING PROVIDER FOR MY INSURANCE CARRIER, I UNDERSTAND THE PHYSICIAN WILL ACCEPT THE INSURANCE CARRIERS ALLOWABLE. IF THE PHYSICIAN IS NOT A PARTICIPATING PROVIDER, I UNDERSTAND I WILL BE RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT BILLED BY THE PHYSICIAN AND THE AMOUNT PAID BY THE INSURANCE CARRIER. IF MY INSURANCE CARRIER HAS NOT PAID WITHIN 90 DAYS, I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT AT THAT TIME AND WILL BE REIMBURSED APPROPRIATELY WHEN MY INSURANCE CARRIER MAKES PAYMENT.

I AM RESPONSIBLE FOR ANY OFFICE VISIT CO-PAYMENT AT THE TIME OF SERVICE.
THERE WILL BE AN ADDITIONAL CHARGE TO ME IF MY BANK REFUSES TO HONOR ONE OF MY CHECKS.
I HEREBY GIVE MY PERMISSION TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT/ANKLE CONDITION.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES (HIPAA):
WE ARE REQUIRED TO OBTAIN YOUR SIGNATURE AS AN ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES. A LINK TO THE COPY OF OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE ON OUR WEBSITE, AND A PRINT COPY IS AVAILABLE WITH THE RECEPTIONIST. THIS POLICY PROVIDES A DETAILED DESCRIPTION OF HOW WE ARE REQUIRED BY FEDERAL LAW TO HANDLE YOUR HEALTH AND PERSONAL INFORMATION. IT ALSO INFORMS YOU ON YOUR RIGHTS WITH REGARDS TO ACCESSING THE INFORMATION AND CONTROLLING ITS DISCLOSURE.

I HEREBY GRANT SAN DIEGO PODIATRY GROUP PERMISSION TO RECEIVE A COPY OF MY MEDICAL RECORDS ELECTRONICALLY.

I UNDERSTAND I AM ENTITLED TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES:

SIGNATURE (PATIENT/GUARDIAN):_____ DATE: _____

PRINT NAME (PATIENT/GUARDIAN): _____ RELATIONSHIP: _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____
_____ _____
_____ _____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

NUMBER OF STAIRS AT HOME: _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN ☐ METAL/NICKEL

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

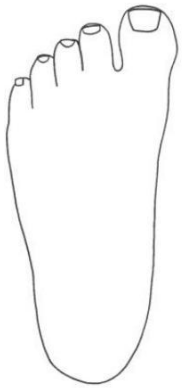
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

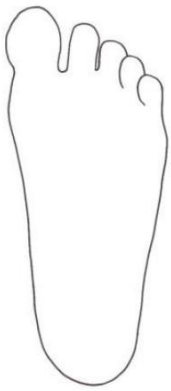
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

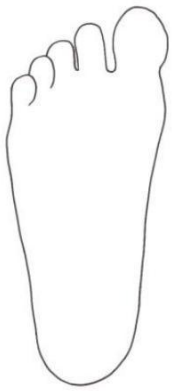


BOTTOM OF FOOT

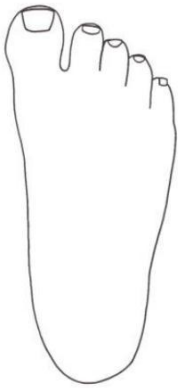
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

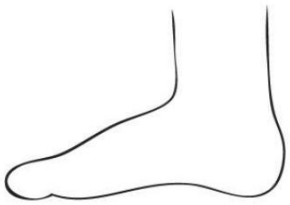


BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____
_____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

IF YES, WAS IT A MOTOR VEHICLE ACCIDENT-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

PRACTICE AND FINANCIAL POLICY

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy. The following is a statement of our **PRACTICE AND FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete and accurate* insurance information and a copy of your identification card, ***both front and back***. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. We will provide procedure codes for you to submit to your insurance necessary for any clarification of expenses. **It is your responsibility to contact your insurance company regarding *preauthorizations, obtaining required referrals (all HMOs require a referral to our office for an initial visit), second opinions, etc.*** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by *cash, check or credit card* (Visa, MasterCard, Discover). There will be a $25.00 charge for *returned checks. Delinquent accounts* will be referred for collection at the discretion of the office manager.

CO-PAYMENTS: Please be prepared to pay all co-payments at the time of service. We do not send bills out for co-payments, so your visit will have to be re-scheduled if you are not prepared to pay the co-payment.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

RECORDS AND FORM COMPLETION REQUESTS:
If you request our office to fill out documents, please allow 7-10 working days for this to be completed. Original patient chart and x-rays are the property of the practice and are required to remain on site. Copies will be processed within 7-10 working days and a fee will be charged.

PRESCRIPTION MEDICATIONS:
The providers will only prescribe narcotic pain medication for acute trauma and/or during the immediate period after surgery. If your pain is chronic you will be referred to a pain management specialist. Please allow 48-72 hours for medication refills. No narcotic medication refills will occur on weekends or after office hours.

ORTHOTICS: Orthotics are a non-covered service by **MOST** insurance plans. In particular, orthotics are a non-covered item for **MEDICARE** and **TRICARE**. We will bill **HMO** plans only if prior authorization is approved. If you have a **PPO** plan, we will contact your insurance to determine if orthotics are a covered benefit. The cost of orthotics is **$940**. In the event that orthotics are not a covered benefit on your health insurance and you wish to purchase them out-of-pocket, we have a discounted **CASH** price of **$550**. If you would like additional pairs of orthotics, insurance will only be billed if additional pairs are approved and covered items by insurance, otherwise we will offer a discounted cash price of **$325**.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill HMOs, Medicare or Tricare, as they are considered non-covered items. In addition, we contract with outside suppliers to provide some supplies through our office. If any of these supplies are used for your treatment you or your insurance will be billed for these supplies by the outside provider. The San Diego Podiatry Group has no part in billing for these supplies.

Please complete the following items:
What is your co-payment per visit: $_____
What is your insurance annual deductible: $ _____
How much of the deductible is current (not yet paid): $_____
(if you are not sure what your current (not yet paid) deductible is, please call your insurance company prior to your visit.)

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

SIGNED_____DATE_____