SOUTHERN CALIFORNIA Foot & Ankle SPECIALISTS

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# New Patient Demographics

Name _____ Birth Date ____/____/____ Age _____ (years)
(First Middle Last) (month / day / year)

SS# ____-____-____ Ethnicity _____ Sex: ☐ Male ☐ Female

Home Address _____, _____ State_____ Zip _____
Street Number / Street Name / Apt. # City

Home Phone (____)____-____ Work Phone (____)____-____ Work Extension _____

Cell Phone (____)____-____ E-Mail _____@_____

☐ Married ☐ Single ☐ Domestic Partnered ☐ Other (i.e.: Widowed) ☐ Full-Time Student ☐ Part-Time Student

Employer Name _____ Employment Status_____

Employer Address _____, _____ State_____ Zip _____
Street Number / Street Name / Suite # City

Parent or Responsible Party Name _____ Relationship to Patient _____
Under 18 Complete Responsible Party Information

Address if Different from Home _____ Day Phone (____)____-____

Spouse / DP Name _____ Day Phone (____)____-____

Emergency Contact Name & Relationship to Pt _____ Day Phone (____)____-____

Primary Care Dr._____
Last Name, First Name

Physician Address _____ Physician Phone (____)____-____

How did you choose SCFAS for your Podiatric needs? ☐ Physician Referral ☐ Insurance Website ☐ Other Medical Referral
☐ Yelp Review ☐ Family Member ☐ Friend/Colleague ☐ SCFAS Website ☐ Other: _____

**Copy of Insurance ID(s) and Completion Required From Computer Billing Service / (949) 625-6889**

Primary Insurance Company _____ ☐ PPO ☐ HMO Co-pay Amount $_____

Are you the Subscriber or Primary Policy Holder of Plan? ☐ Yes ☐ No I.D. # _____

Name of Subscriber _____ Subscriber Birth Date ____/____/____

Patient's Relationship to Subscriber_____ Subscriber's Employer _____
(i.e.: Spouse, Child, Other)

Do you have Add'l Insurance? ☐ Yes ☐ No 2nd Ins. _____ I.D. # _____

Name of Subscriber 2nd Insurance _____ Subscriber Birth Date ____/____/____

Patient's Relationship to Subscriber_____ Subscriber's Employer _____
(i.e.: Spouse, Child, Other)

Is visit related to accident or injury? ☐ Yes ☐ No If Yes, Type Injury: ☐ Auto ☐ Work ☐ Other Date of Injury_____

Place of Injury _____ How were you injured? _____

Assignment of Benefits: I hereby assign payment directly to Southern CA Foot & Ankle Specialists, the insurance benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization. I also authorize a photocopy of this assignment as if it were an original copy. If it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay the reasonable attorney's fee and collection expenses. Further, I understand that coinsurance, unsatisfied deductible amounts, etc. are requested at the time of services unless other financial arrangements are made in advance. If you are unable to keep your scheduled appointment, please notify our office 24 hours in advance.

_____ _____
Signature Date

SOUTHERN CALIFORNIA Foot & Ankle SPECIALISTS

## Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Rash | ☐ Yes | ☐ No |
| Allergies to Anesthetics | ☐ Yes | ☐ No | Eye Problems | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Allergies to Medicine or Drugs | ☐ Yes | ☐ No | Fainting | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Foot or Leg Cramps | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Angina | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Special Diet | ☐ Yes | ☐ No |
| Artificial Heart Valves or Joints | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Hemophilia | ☐ Yes | ☐ No | Swelling in Ankles, Feet | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No | Hepatitis or Jaundice | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Tired Feet | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Kidney Problems | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Low Blood Pressure | ☐ Yes | ☐ No | Varicose Veins | ☐ Yes | ☐ No |
| Chronic Diarrhea | ☐ Yes | ☐ No | Neuropathy | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No | Phlebitis | ☐ Yes | ☐ No | Weight Loss, unexplained | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | | | |
| Ear Problems | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No | | | |

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

## Medications

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

## Allergies

| | |
|---|---|
| ☐ Adhesive/Tape | ☐ Local Anesthetics |
| ☐ Anticoagulant Therapy | ☐ Novocaine |
| ☐ Aspirin | ☐ Penicillin |
| ☐ Codeine | ☐ Seafoods |
| ☐ Demerol | ☐ Sulfa |
| ☐ Iodine | |

Other _____

## Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

SOUTHERN CALIFORNIA
Foot & Ankle
SPECIALISTS

This page serves to inform you of the privacy practices of Southern California Foot & Ankle Specialists and its representatives. The privacy of your medical information is important to us. We intend to honor your privacy in every way possible.

By signing below you will allow us to disclose your personal health information:

- For treatment of your medical condition.
- For help in attaining the maximum benefits allowed by your insurance company.
- To any 3rd party representatives also working in the treatment of your medical diagnosis.

We respect your rights in maintaining the utmost in privacy in regards to your individual health information. We will not release any of your health information to non-medical entities without your prior written permission.

Southern California Foot & Ankle Specialists maintains physical and electronic safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets and controlled computer network systems and password accounts.

We will only disclose your medical information to your health plan or other health care professions or facilities for purposes of diagnosis or treatment of your medical condition. If you prefer that we do not disclose any or all of your medical condition(s), please inform us so that we may take any necessary precautions.

Please check the box below to indicate whether you would provide consent to receiving automated text and voice messages at the phone number(s) provided on previous page for appointment reminders.

[ ] Yes [ ] No

NOTICE TO CONSUMERS

Doctors of Podiatric Medicine are licensed and regulated by the Medical Board of California.
(800)633-2322
www.bpm.ca.gov

_____ _____

Signature Date

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