

# Welcome to Our Office

## Saddleback Valley Podiatry Group

23961 Calle de la Magdalena, Suite 143, Laguna Hills, CA 92653

### Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
Name You Go By \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M  F   
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ Marital Status: M  S  W  D   
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

### Referring Information

Who may we thank for referring you? \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Previous Podiatrist \_\_\_\_\_  
What is your chief foot complaint? \_\_\_\_\_

### Insured Person or Subscriber (if other than above)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex: M  F   
Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Information

Primary Insurance \_\_\_\_\_ Group # \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insured Name \_\_\_\_\_ ID# \_\_\_\_\_

### Eligibility Waiver

I authorize my insurance company to pay any and all charges rendered on my behalf directly to Saddleback Valley Podiatry Group. I will be responsible for and will guarantee payment on any and all charges which may not be paid or covered by my insurance company. I certify that the information given, including insurance coverage is complete and correct. I understand I will be charged \$50 if I fail to cancel my appointment within 24 hours.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_

Your email address will never be shared without your permission but will be used for communication from the office

# Medical History

What is your foot problem?

When did problem begin? \_\_\_\_\_ Date (if an injury): \_\_\_\_\_

Describe any accident/event \_\_\_\_\_

Previous X-rays?  Yes  No      Previous MRI?  Yes  No      Previous CT?  Yes  No

Describe any previous treatment or home remedies \_\_\_\_\_

Have you ever had foot surgery?  No  Yes      When and by whom? \_\_\_\_\_

Are you here for a:  Consultation  Surgical Evaluation  Second Opinion  Workers Compensation Evaluation

### Do you have or have you ever been treated for:

Diabetes I or II (circle)  Yes  No

Heart Disease  Yes  No

High Blood Pressure  Yes  No

Poor Circulation  Yes  No

Problems Healing  Yes  No

Kidney Disease  Yes  No

Asthma  Yes  No

Autoimmune Disease  Yes  No

HIV  Yes  No

Sleep Apnea  Yes  No

List other health problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

How much are you on your feet at work?

20%  40%  60%  80%  100%

Do you smoke?  Yes packs per day \_\_\_\_  No

Do you drink alcoholic beverages?

None  Rarely  Moderately  Daily  Quit

List any sports/activities: \_\_\_\_\_

Please list previous medical or surgical problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If female, are you pregnant?      Yes      No

Your Name: \_\_\_\_\_

### Allergies to Medications or Materials:

Antibiotics (please list below)  Yes  No

Pain Medication (Codeine, Vicodin)  Yes  No

Local anesthetics  Yes  No

Adhesive tape  Yes  No

Latex  Yes  No

Iodine  Yes  No

Type of reaction: \_\_\_\_\_

Any Other Allergies: \_\_\_\_\_

\_\_\_\_\_

### Do you take any of the following medications?

	Yes	No	Medication
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral diabetic medication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood thinner	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart medication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Water pills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth control pills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anti-depressant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Please list other medications:			_____
			_____
			_____

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### Privacy Practices and Consent

The Health Insurance Portability & Accountability Act of 1996 requires that all medical records and other individually identifiable health information used or disclosed by this office be kept properly confidential. The individual is also provided the right to request confidential communications or that a communication of protected health information (PHI) be made by alternative means.

**I wish to be contacted in the following manner (circle all that apply):**

1. Home Telephone \_\_\_\_\_
  - a. OK to leave message with spouse
  - b. OK to leave message with detailed information
  - c. Leave message to call the office only
2. Work Telephone \_\_\_\_\_
  - a. OK to leave message with detailed information
  - b. Leave message to call the office only
3. Written Communication
  - a. OK to mail to my home address
  - b. OK to mail to my work or office address
  - c. OK to fax to this number \_\_\_\_\_
  - d. OK to exchange information with referring doctors and treatment facilities
4. Other \_\_\_\_\_

_____	_____
Patient or Guardian Signature	Date
_____	_____
Print Name	Birth Date

**I authorize your office to disclose my health information to the following people if needed**

1. \_\_\_\_\_
2. \_\_\_\_\_