Welcome to Our Office

Saddleback Valley Podiatry Group
24012 Calle de la Plata, Suite 135, Laguna Hills, CA 92653
(949) 768-9495

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 show up for my appointment or 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? 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	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
Sleep Apnea	Yes	No
Hepatitis	Yes	No
HIV	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: ____________________

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			____________
Oral diabetic medication			____________
Blood thinner			____________
Heart medication			____________
Water pills			____________
Birth control pills			____________
Anti-depressant			____________

Please list other medications: ____________________

____

____

____

Please list previous medical or surgical problems: ____________________

____

If female, are you pregnant? Yes No

Preferred Pharmacy: ____________________ Phone Number: ____________________

Your Name: ____________________

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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. ____