



# MERCED PODIATRY GROUP

**James Huish D.P.M.**

**Steven Bailey D.P.M.**

*Diseases, Injuries, and Surgery of the Foot and Ankle  
American Board of Podiatric Surgery & American College of Foot Surgeons*

700 W. Olive Avenue, Suite C Merced, CA 95348

Office (209) 384-3668, Fax (209) 384-3264

## WELCOME TO OUR OFFICE

We are very pleased to be of service to you. Please fill in all the appropriate blanks below. The information is important for your health and our records. If you need help, do not hesitate to ask. All information is **strictly confidential** and complies with all HIPPA, Federal, and State regulations.

### **PATIENT / INSURANCE INFORMATION**

Date: \_\_\_\_\_ *PLEASE HAVE YOUR INSURANCE CARD AVAILABLE FOR THE RECEPTIONIST TO COPY.*

PATIENT: \_\_\_\_\_ M/F \_\_\_\_\_  
Last Name First Middle (sex, circle) Date of Birth Social Security Number

PH # : \_\_\_\_\_ DL/ID# : \_\_\_\_\_ Single/Married/Divorced/Widowed  
Home Work (Please circle current marital status)

PATIENT'S ADDRESS: \_\_\_\_\_  
Street/ P.O. Box City State Zip Code

MAILING ADDRESS: \_\_\_\_\_  
Street/ P.O. Box City State Zip Code

EMPLOYER (or parent's): \_\_\_\_\_  
Company Name Address Phone Number

EMERGENCY CONTACT: \_\_\_\_\_  
Name Phone # Relationship to patient

PHYSICIAN: \_\_\_\_\_ / \_\_\_\_\_  
Primary Care Doctor Other Medical Specialist

REFERRED BY: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_  
Name Policy # (or see card) Group #

INSURED SUBSCRIBER: \_\_\_\_\_  
(If different from above) Relation Last Name First Name M.I. Phone Number

INSURED INFORMATION: \_\_\_\_\_  
(If different from above) Address Date of Birth

CO-PAY: \$ \_\_\_\_\_  
Social Security # Employer Work Phone #

SECONDARY INSURANCE: \_\_\_\_\_  
Name Policy # (or see card) Group #

INSURED SUBSCRIBER: \_\_\_\_\_  
(If different from above) Relation Last Name First Name M.I. Phone Number

### **ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize the above Insurance Company(s) to pay the Merced Podiatry Group the Medical and Surgical Benefits allowable and otherwise payable under my Insurance Policy. I understand I am financially responsible to Merced Podiatry Group for the charge not covered by this assignment. Interest rate, 1.5% per month for delinquent accounts.

**HIPPA Privacy:** I acknowledge that I was provided a copy of the "Notice of Privacy Practices." I understand this office complies with all privacy and security standards and laws and any questions have been answered to my satisfaction.

SIGNATURE (OR PARENT/GUARDIAN): \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE FILL IN MEDICAL INFORMATION ON THE BACK**





# MERCED PODIATRY GROUP

**James Huish D.P.M.**

**Steven Bailey D.P.M.**

*Diseases, Injuries, and Surgery of the Foot and Ankle  
American Board of Podiatric Surgery & American College of Foot Surgeons*

700 W. Olive Avenue, Suite C Merced, CA 95348

Office (209) 384-3668, Fax (209) 384-3264

## PATIENT MEDICAL INFORMATION

All medical information is necessary to provide proper medical care. If you need help, please do not hesitate to ask. All information is **strictly confidential** and complies with all HIPPA, Federal, and State regulations.

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

PATIENT'S NAME: \_\_\_\_\_ Age: \_\_\_\_\_  
Last Name First Middle

DOCTOR: \_\_\_\_\_ Y / N  
Primary Care Physician Referred by Dr. Other Medical Specialist

CURRENT FOOT COMPLIANT/PROBLEM : \_\_\_\_\_

Podiatric History: \_\_\_\_\_  
Prior Foot Problems (Please List) Podiatrist

**ALLERGIES:** Please indicate by circling "Yes" if you have allergies to the following:

Yes Penicillin	Yes Vicodin	Yes Tetanus
Yes Sulfa	Yes Tape	Yes Novocain / Lidocaine
Yes Codeine	Yes Aspirin	Yes Erythromycin
Yes Other: _____		

LIST MEDICATIONS CURRENTLY TAKING: (or a list for us to copy) \_\_\_\_\_

## MEDICAL PROBLEMS

Please indicate by circling "Yes" if you have any of the following medical problem:

Yes Diabetes	Yes Joint Pain/Stiffness	Yes Pregnant (or intend to be)	Yes Headaches
Yes Hypertension	Yes Arthritis	Yes Epilepsy/Seizures	Yes Fainting/Dizzy
Yes Heart Disease	Yes Gout	Yes Swelling Legs/Feet/Ankles	Yes Depression
Yes Stroke	Yes Kidney Disease	Yes Leg/Feet Cramps	Yes Psychiatric
Yes Anemia	Yes Stomach/Gallbladder	Yes Numbness/Nerve	Yes Polio/Paralysis
Yes Thyroid	Yes Lung/Pulmonary	Yes Circulation/Phlebitis	Yes Liver/Hepatitis
Yes Asthma	Yes Cancer	Yes Varicose Veins	
Yes Other: _____			

Do you use or have used: Yes Tobacco Yes Alcohol Yes Drugs

**FAMILY HISTORY:** Please circle "Yes" if you have a family history of the following:

Yes Diabetes	Yes Cancer	Yes Asthma/Lung	Yes Psychiatric
Yes Arthritis	Yes Heart Disease	Yes Hypertension	Yes Foot Problems
Yes Other: _____			

**SURGICAL HISTORY:** Please circle "Yes" if you have had the following performed:

Yes Appendix	Yes Heart Surgery	Yes Gallbladder	Other Surgeries: _____
Yes Fractures	Yes Vascular Surgery	Yes Hysterectomy	_____

Hospitalized: \_\_\_\_\_  
Problem Date Problem Date

I HEREBY GIVE MY PERMISSION TO THE DOCTOR TO EXAMINE, TO PHOTOGRAPH, X-RAY, TEST, ADMINISTER TREATMENT, AND TO PERFORM SUCH MINOR PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY MEDICAL PROBLEM.

PATIENT'S SIGNATURE (OR PARENT/GUARDIAN): \_\_\_\_\_ DATE: \_\_\_\_\_