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

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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 High blood pressure	*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: _____