MERCED PODIATRY GROUP

Dr. James Huish D.P.M **Dr. William C. Hurtt D.P.M**

Diseases, Injuries, and Surgery of the Foot and Ankle

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 #

Height_____ Weight_____

PH # :_____ DL/ID# :_____ Single/Married/Divorced/Widowed
Mobile # 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:_____ _____
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

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* Fainting/Dizzy	*Yes* Arthritis	*Yes* Epilepsy/Seizures
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	Foot 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: _____