SAN MATEO PODIATRY GROUP

EXCELLENCE IN FOOT AND ANKLE CARE SINCE 1917

For your convenience, and to simplify the billing process, our practice keeps credit cards securely on file

This is done to cover incidental charges, such as copayment, coinsurance, and deductible.

Please present your driver's license, health insurance card, and a major credit card to the front desk to begin the registration process.

Date: _____

Name: _____ _____ _____ Sex: □ M □ F
Last First MI

Age: _____ Date of Birth: _____ Social Security Number: _____
mm/dd/yy

Home Address: _____

City: _____ State: _____ Zip: _____

Preferred Contact:
□ Mobile Phone: _____
□ Home Phone: _____
□ Email: _____

How did you hear about us?
□ Google/Internet Search
□ Existing Patient: _____
□ Physician Referral: _____

Please provide an emergency contact (friend or family member) with which we can share your information:

Name: _____ Relation: _____ Phone: _____

Doctors and Pharmacies

Who is your family doctor? (If different from referring physician above)

Primary Care Doctor: _____

What is your preferred pharmacy? (All prescriptions are sent electronically)

Pharmacy: _____ Location (Zip Code): _____

Past Medical History:

□ No Past Medical History or Conditions

Have you ever had any of the following health conditions?

Abnormal Bleeding	□ Yes	□ No	Fibromyalgia	□ Yes	□ No	Open Sores/Wounds	□ Yes	□ No
Acid Reflux	□ Yes	□ No	Gout	□ Yes	□ No	Pneumonia	□ Yes	□ No
Anemia	□ Yes	□ No	Heart Attack	□ Yes	□ No	Polio	□ Yes	□ No
Arthritis	□ Yes	□ No	Heart Disease/Failure	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Asthma	□ Yes	□ No	Hepatitis	□ Yes	□ No	Sickle Cell Disease	□ Yes	□ No
Back Trouble	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Skin Disorder	□ Yes	□ No
Blood Clots	□ Yes	□ No	HIV+/AIDS	□ Yes	□ No	Sleep Apnea	□ Yes	□ No
Blood Transfusion	□ Yes	□ No	Liver Disease	□ Yes	□ No	Stomach Ulcers	□ Yes	□ No
Bronchitis	□ Yes	□ No	Low Blood Pressure	□ Yes	□ No	Stroke	□ Yes	□ No
Cancer	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Diabetes	□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Emphysema	□ Yes	□ No	Neuropathy	□ Yes	□ No			

Other Conditions: _____

Past Surgical History:

Please list all prior surgeries and hospitalizations.

□ No Prior Surgeries or Hospitalizations

Surgery/Hospitalization: Date:

_____

_____

_____

Medications: For improved prescription safety and for your convenience, we are able to download this information electronically from your pharmacy.

□ No Current Prescription Medications, over the counter Medicines, or herbal or dietary supplements

Please list all current prescriptions, over the counter medications, and herbal or dietary supplements.

Medication Name: Dose: How Often:

_____

_____

Allergies:

Please list all food and medicine allergies and adverse reactions.

□ No Allergies or adverse reactions

□ Medication (specify)
□ Anesthesia
□ Food/Shellfish
□ Iodine
□ Tape
□ Latex

Other Allergies: _____

Family History:

Marital Status:

□ Single
□ Partnered
□ Married
□ Separated
□ Divorced
□ Widowed

Do others depend upon you for their care? □ Yes □ No

□ Children □ Elderly or disabled family member □ Other: _____

Do you have a family history (mother, father, siblings) of:

□ Cancer
□ Diabetes
□ Heart Disease
□ High Blood Pressure
□ Neurologic Disease
□ Stroke
□ Rheumatoid Arthritis
□ Other:_____

Social History:

Employer:_____

Occupation: _____

What percentage of your workday is spent standing or walking?

□ 10% □ 25% □ 50% □ 75% □ 100%

Exercise: □ Never □ Occasional □ Weekly □ Daily

Alcohol: □ Never □ Occasional □ Weekly □ Daily

Tobacco: □ Never □ Quit: How Long Ago? _____

□ Smoke_____ packs/day for _____years

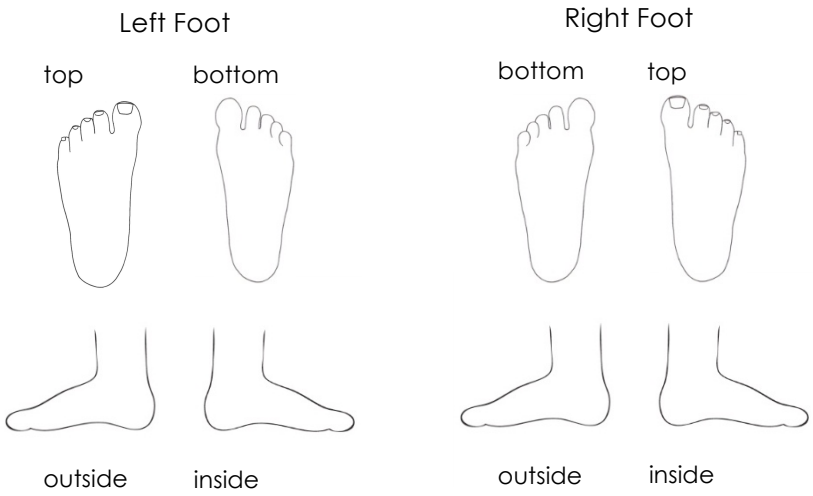
Height / Weight:

Please provide your height and estimated weight:

Height:_____ Weight: _____

What problem brings you to our office today?_____

Where is the pain/problem located? Please mark on the pictures below.



How long ago did this problem start? _____

Did your pain or problem begin: □ suddenly □ gradually

Was this problem caused by an injury? □ Yes □ No

If yes, was it a work-related injury? □ Yes □ No

If Yes, Please Describe:_____

How would you describe your pain?

□ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Other:_____

How would you rate your pain on a scale from 0 to 10? (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)

Since your pain or problem began, has it: □ worsened □ improved □ remained unchanged

What makes your pain or problem feel worse?

□ Standing □ Walking □ Running □ Daily activities □ Dress shoes □ High heels

□ Other:_____

What makes your pain or problem feel better?

□ Resting □ Ice □ Elevation □ Wrapping □ Massage

□ Other:_____

What treatments have you had for this problem?_____

How has this problem affected your lifestyle or ability to work? _____

Authorization and Assignment of Benefits

Acknowledgement of Notice of Privacy Practices (HIPAA): I understand that I am entitled to receive a copy of the notice of privacy practices, available upon request and on our website.

Completeness and Accuracy: I have answered the questions on this form accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Please be advised that by completing this form, we are not establishing a physician-patient relationship; The Doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Treatment Authorization: I give consent to the Doctors of San Mateo Podiatry Group to perform office based medical procedures to treat my condition, symptoms, illnesses, or injuries. I also give the same consent for my minor child or children.

Medication History Authorization: I give consent to the Doctors of San Mateo Podiatry Group to access and download my prescription medication history.

Release of Medical Information and Assignment of Benefits: I authorize the release of all information necessary to submit, document, and process insurance claims on my behalf. I assign to San Mateo Podiatry Group the payment and benefits of any and all health insurance and personal injury insurance policies to which I may be entitled.

Financial and Office Policies

I accept the Financial and Office Policies of San Mateo Podiatry Group, A Professional Corporation, specifically:

As a courtesy to our patients, the practice submits charges to contracted insurance plans. We are obligated to collect patient responsibility amounts such as co-payment, co-insurance, deductible, and any non-covered services at the time of service. Sometimes, exact coverage cannot be determined until the insurance company receives the claim.

To simplify billing, and for your convenience, the practice maintains credit cards securely on file. We will notify you prior to any charges being submitted to your card.

If services provided are determined by your health plan to be fully or partially non-covered for any reason, you agree to waive your contractual coverage and agree to be responsible for the complete charge.

Further, if for any reason, your health insurance company does not pay our office within sixty days, we will submit outstanding charges to the credit card on file.

Appointment Cancellation Policy: Patients who fail to arrive within fifteen minutes for their scheduled appointments or who cancel with less than 72 hours notice will be charged a fee of $150 to the credit card on file.

Copy: An electronic copy of this agreement shall be binding as original.

Acceptance of our financial and office policy is mandatory in order to complete your registration, receive medical evaluation, and treatment.

_____	_____
Patient Name (print)	Date
_____	_____
Signature of Patient/Legal Guardian	Relationship (if applicable)