SAN MATEO PODIATRY GROUP
EXCELLENCE IN FOOT AND ANKLE CARE SINCE 1917

Welcome!

Please present your driver's license, health insurance card, and a major credit card to the front desk to begin the registration process. Our practice keeps credit cards securely on file for your convenience and to simplify the medical billing process. This is done to cover incidental charges, such as copayment, coinsurance, and deductible.

Date: _____

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

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

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): _____

Please provide your height and estimated weight:

Height:_____ Weight: _____

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 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? _____

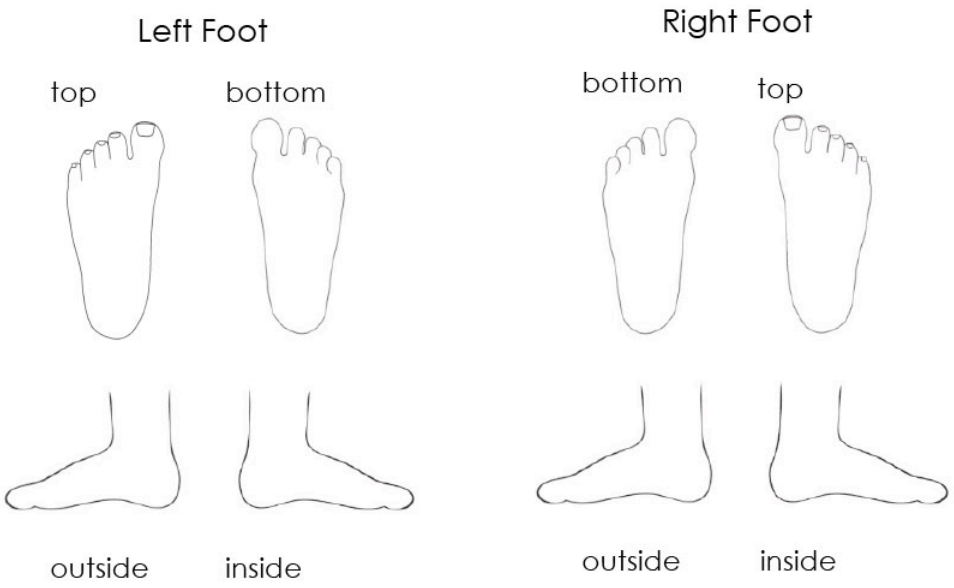
□ Smoke_____ packs/day for _____years

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

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

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? _____

Agreement, Practice and Financial Policies

Introduction

Welcome, and Thank You for choosing San Mateo Podiatry Group for your foot and ankle care. Please review and agree to our Practice and Financial policies; your clear understanding is important to our professional relationship.

Practice Policies

I acknowledge that I have received and reviewed the Practice Policies of San Mateo Podiatry Group. A copy is available upon request and can be obtained from practice website.

Financial Policies

To continue to *deliver excellence* to our clients, our policy is simple:

- For treatments that are covered by health insurance, we ask that all patient responsibility amounts (co-payment, co-insurance, and deductible) be paid at the time of your visit.

- For treatments that are not covered, we ask you to waive your contractual coverage and be responsible for the associated costs.

Credit Cards

We keep credit cards securely on file to pay for incidental charges, such as copayment, co-insurance and deductible amounts; All account balances due at sixty days will be charged to the credit card on file. We always notify patients prior to any charges.

Electronic Signature

This completed agreement will be stored in your client file, and an electronic copy shall be binding as the original; A copy is available upon request.

Physician - Patient Relationship

The Doctor will conduct an evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient; completing this form does not establish a doctor-patient relationship.

I accept and agree to the Practice Policies and Financial Policies of San Mateo Podiatry Group.

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