West Beverly Podiatry Group

Welcome To Our Office

Pharmacy (name/number): ______________________________

Preferred Language: ____________________

E-Mail: ______________________________ Cell Phone: ____________________

PATIENT REGISTRATION (*PLEASE COMPLETE THE FOLLOWING INFORMATION*)

Date ____________ Home Phone: ( ) ____________ Sex ☐ Male ☐ Female Age ______

Last Name ____________ First Name ____________ Initial ______ Date of Birth ____________

Street ____________ City ____________ State ______ Zip ______ Race ______

SS# ____________ Driver's Lic# ____________ Ethnicity ____________

Marital Status ____________ Name of Spouse ____________ Children? Yes / No Ages ______

Employer ______________________________ Phone ____________

Street ____________ City ____________ Zip ______ State ______

Occupation May we call you ☐ Yes ☐ No Work Hours Ext.

FINANCIALLY RESPONSIBLE PARTY (*PLEASE COMPLETE THE FOLLOWING INFORMATION*)

Same as Above ☐Yes ☐No Relationship? ____________ Phone ( ) ____________

Last Name ____________ First Name ____________ Initial ______

Street ____________ City ____________ State ______ Zip code ______

SS# ____________ Driver's License ____________ Date of Birth / /

Employer ______________________________ Phone ____________ Ext ______

Street City State Zip

INSURANCE INFORMATION (*FOR OFFICE USE ONLY*)

Primary Insurance/HMO ____________ Health Plan: ____________ Phone ( ) ____________

Insured's ID# ____________ Group # ____________ Effective Date: ____________

Insured's Name ____________ Street (PO Box) ____________

City ____________ State ____________ Zip Code ____________

Secondary Insurance/ HMO ____________ Health Plan: ____________ Phone ( ) ____________

Insured's ID# ____________ Group # ____________ Effective Date: ____________

Insured's Name ____________ Street (PO Box) ____________

City State Zip Code

IN CASE OF AN EMERGENCY (*PLEASE COMPLETE THE FOLLOWING INFORMATION*)

Who should be notified? ______________________________

Relationship ____________ Phone ( ) ____________

Who may we thank for referring you?

Method of Contact:

☐Home Phone ☐Cell Phone ☐Leave Message at home ☐Leave Message at Cell

☐Leave Message at Emergency Number If I cannot be contacted

☐Leave Message with Relative: ______________________________

Other: ______________________________

PATIENT MEDICAL HISTORY OVERVIEW *(PLEASE COMPLETE THE FOLLOWING INFORMATION)*

What are your foot problems? ______

When did problem begin? Date: ______
Describe any accident/event: ______

First visit to a Doctor for this problem? ☐ Yes ☐ No
Previous x-rays? ☐ Yes ☐ No If yes, Date: ______
Where are they now? ______
Describe any previous treatment or home remedies? ______

Have you been treated for:

☐ Low back pain	☐ Intoeing	☐ Heel pain
☐ Broken foot bone(s)	☐ Callouses	☐ Rash
☐ Hammertoes	☐ Neuroma	☐ Corns
☐ Ankle injury	☐ Knee pain	☐ Arch pain
☐ High arch feet	☐ Bunions	☐ Flat feet
☐ Ingrown nails	☐ Childhood foot problems	

Do you have or have you ever been treated for:

☐ Diabetes	☐ Anemia	☐ Blood disease
☐ Hepatitis	☐ Phlebitis	☐ Heart trouble
☐ HIV	☐ High Blood Pressure	

Are you slow to heal after cuts?	☐ Yes	☐ No
Any abnormal bruising or bleeding?	☐ Yes	☐ No
Any pain in calves or buttocks when walking?	☐ Yes	☐ No
Does rest relieve the pain?	☐ Yes	☐ No
Do your feet hurt at night?	☐ Yes	☐ No
Are you currently taking any medications?	☐ Yes	☐ No

Please List: ______

Height: ______ Weight: ______ Shoe Size: ______
How much are you on your feet at work? ______
☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%
List any sports/activities: ______

Do you smoke? ☐ Yes ☐ No Packs/Day: ______ Years: ______
Did you ever smoke? ☐ Yes ☐ No Packs/Day: ______ Years: ______
If you quit, how long ago? ______
Alcoholic beverages?
☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit
Non-Prescribed Drugs/Recreational(not including over the counter)?
☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit
What kind? ______

Allergies to injections, oral or topical administration of:

Penicillin or other antibiotics?	☐ Yes	☐ No	☐ Don't Know
Narcotics? (Morphine, Codeine, Demerol....)	☐ Yes	☐ No	☐ Don't Know
Local anesthetics?	☐ Yes	☐ No	☐ Don't Know
Pain remedies?	☐ Yes	☐ No	☐ Don't Know
Latex?	☐ Yes	☐ No	☐ Don't Know
Adhesive tape?	☐ Yes	☐ No	☐ Don't Know
Any other drug, medication or treatment?	☐ Yes	☐ No	☐ Don't Know

If "yes" to any of the above, please explain: ______

Have you had a serious illness?	☐ Yes	☐ No
Have you been hospitalized or under lengthy medical care?	☐ Yes	☐ No
Have you had any surgery?	☐ Yes	☐ No

If "yes" to any of the above, please explain:

PATIENT PHYSICIANS *(PLEASE COMPLETE THE FOLLOWING INFORMATION)*

Family Physician: ______ Date Last Seen: ______
Phone: ( ) ______
City: ______ State: ______
Did your family Dr. or pediatrician refer you to us? ☐ Yes ☐ No
Specialist Dr.: ______ Specialty: ______
Date Last Seen: ______ Phone: ( ) ______
City: ______ State: ______
Did your specialist Dr. refer you to us?
☐ Yes ☐ No

Previous Podiatrist: ______ Date Last Seen: ______
Phone: ( ) ______
City: ______ State: ______

Did your podiatrist refer you to us?	☐ Yes	☐ No
Did you Dr. send you for consultation?	☐ Yes	☐ No
Did your Dr. send you for a surgical evaluation?	☐ Yes	☐ No
Did your Dr. send for a 2nd opinion on surgery?	☐ Yes	☐ No
Did you independently come for a 2nd opinion?	☐ Yes	☐ No

FAMILY HISTORY *(PLEASE COMPLETE THE FOLLOWING INFORMATION)*

Has any blood relative had:			If "Yes," please indicate below who:
Tuberculosis?	☐ Yes	☐ No	______
Cancer or tumor?	☐ Yes	☐ No	______
High blood pressure?	☐ Yes	☐ No	______
Heart trouble?	☐ Yes	☐ No	______
Diabetes?	☐ Yes	☐ No	______
Birth abnormalities?	☐ Yes	☐ No	______
Arthritis?	☐ Yes	☐ No	______
Stroke	☐ Yes	☐ No	______
Foot problems?	☐ Yes	☐ No	______

Patient Name: ______ Date: ______

Conditions of Treatment

Medical and Surgical Consent

The undersigned consents to any x-ray examination, photographing, televising, laboratory and therapeutic procedures, anesthesia, medical or surgical treatment rendered to the patient under the general and special instructions of the physician. It is the patient's privilege to refuse any recommended medical procedure in which case the patient will be requested to sign a refusal form thereby releasing the physician and medical group from any responsibility as the possible outcome of the patient's condition.

Release of Information

West Beverly Podiatry Group may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the clinic for all or part of **West Beverly Podiatry Group's** charge, including, but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds or the patient's employer.

Privacy Practice Act

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Assignment of Insurance Benefits

In the event the patient is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to **West Beverly Podiatry Group** for application to patient's bill, and it is agreed that **West Beverly Podiatry Group** may receipt for any such payment shall discharge that said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges by this assignment. It is my responsibility to pay any deductible amount or co-insurance.

Financial Agreement

The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of **West Beverly Podiatry Group** in accordance with the regular rates and terms of **West Beverly Podiatry Group**. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bare interest at the legal rate.

I understand that fees for service are payable in full at the time of service, unless other arrangements are made in advance.

There will be a $30.00 service charge for any appointment that is not cancelled 24 hours prior to his or her appointment.

It is the policy of this office to bill your insurance for reimbursement. However; we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

The undersigned certifies that he has read the foregoing and is the patient or is duly authorized by the patient's general agent to execute the above and accept its terms.

Patient Name (Please Print): ______________________________________

______________________________ ______________

PATIENT SIGNATURE DATE

If the PATIENT is a minor or incompetent, the parent or guardian should sign below and in addition the minor or incompetent PATIENT should sign above, if possible.

______________________________ ______________

PARENT/GUARDIAN DATE

West Beverly Podiatry Group

1417 W. Beverly Blvd. Ste.#104 Montebello, CA 90640 Phone: (323) 721-6026 Fax: (323) 887-1891

NOTIFICATION OF BILLING PROCEDURES

Medicare—Unauthorized/Unbillable Charges

Medicare requires a minimum of 60 days between visits for at risk patient foot care and nail grinding. If the diagnosis changes (i.e., fracture, trauma, infections, etc.) the visit may be billed under the new diagnosis. Any charges occurring outside these guidelines will be the responsibility of the patient.

Non-covered Services

Insurance providers will decline payment for non-covered services or supplies. Post-op shoes, certain ankle braces, orthotic devices and pads are some examples of non-covered supplies.

Unauthorized Visits

Some insurance providers require prior authorization for office visit or procedure. It is the patient's responsibility to obtain authorization before their office visit. If authorization is not obtained, the patient will be responsible for all costs incurred by their office visit.

Deductible

The deductible is the patient's responsibility. The patient's insurance provider will be billed to determine the amount applied toward the patient's deductible. Insurance information must be available on the day of the visit or full payment will be required at that time.

It has been explained to me that the procedure and services described above may not be covered by my insurance provider and any claims would likely be denied. I agree to be personally responsible for payment of all charges for these services.

______________________________ ____________

Patient/Guardian Signature Date

Patient Name (please print) ______________________________