Jeri M. Gruenes DPM, RD
Medicine and Surgery of the Foot and Ankle
1041 E. Yorba Linda Blvd. Suite 201 Placentia, CA 92870
714-985-9168 FAX 714-985-9161

PATIENT INFORMATION SHEET

NAME: _____ DATE: ___/___/___ DATE OF BIRTH: ___/___/___
(LAST) (FIRST)

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE #: _____ May we leave a message? ☐ Yes ☐ No

CELL PHONE #: _____ May we leave a message? ☐ Yes ☐ No Is it ok to contact via txt: ☐ Yes ☐ No

EMAIL ADDRESS: _____ Is it ok to contact via e-mail: ☐ Yes ☐ No

SSN: _____ MARITAL STATUS: S ☐ M ☐ D ☐ W ☐ STUDENT ☐ SEX ☐ M ☐ F

EMERGENCY CONTACT:_____
(NAME) (CONTACT #) (RELATIONSHIP)

PHARMACY NAME: _____ CITY: _____ STREET: _____

Primary Language: _____ Ethnicity: _____ Race: _____

Primary Care Physician:_____

Office #:_____ Date of last visit: _____

Did your Physician refer you to our office: Y N Reason: _____

How were you referred to our office? _____

Who is responsible for the bill (if other than patient)?

Name: _____ Relationship: _____

Home Address:_____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE #: _____ CELL PHONE #: _____

Primary Insurance:_____

ID #: _____ GROUP #: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder DOB: _____ SSN #: _____-_____-_____

Secondary Insurance:_____ _____

ID #: _____ GROUP #: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder DOB: _____ SSN #: _____-_____-_____

<u>NOTE:</u> YOU MUST INFORM THE OFFICE OF ALL INSURANCE CHANGES. IN THE EVENT THE OFFICE IS NOT INFORMED YOU WILL BE RESPONSIBLE FOR ANY CHARGES DENIED.

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NAME: _____ **DOB:** _____
(LAST) (FIRST)

Allergies: ☐ None Known ☐ Tape ☐ Latex ☐ Anesthesia ☐ Medication: _____

_____

Have you ever had any of the following conditions?

Acid Reflux	**Y**	**N**		**Fibromyalgia**	**Y**	**N**		**Neuropathy**	**Y**	**N**
Anemia	**Y**	**N**		**Gout**	**Y**	**N**		**Open Sores**	**Y**	**N**
Arthritis	**Y**	**N**		**Heart Attack**	**Y**	**N**		**Pneumonia**	**Y**	**N**
Asthma	**Y**	**N**		**Heart Disease/Failure**	**Y**	**N**		**Polio**	**Y**	**N**
Back Trouble	**Y**	**N**		**Hepatitis**	**Y**	**N**		**Rheumatic Fever**	**Y**	**N**
Bladder Infections	**Y**	**N**		**HIV+/AIDS**	**Y**	**N**		**Seizures**	**Y**	**N**
Abnormal Bleeding	**Y**	**N**		**High Blood Pressure**	**Y**	**N**		**Skin Disorder**	**Y**	**N**
Blood Clots	**Y**	**N**		**Kidney Disease**	**Y**	**N**		**Substance Abuse**	**Y**	**N**
Blood Transfusion	**Y**	**N**		**Liver Disease**	**Y**	**N**		**Stomach Ulcers**	**Y**	**N**
Bronchitis/Emphysema	**Y**	**N**		**Low Blood Pressure**	**Y**	**N**		**Stroke**	**Y**	**N**
Cancer	**Y**	**N**		**Migraine Headaches**	**Y**	**N**		**Thyroid Disease**	**Y**	**N**
Diabetes	**Y**	**N**		**Mitral Valve Prolapse**	**Y**	**N**		**Tuberculosis**	**Y**	**N**
Other Conditions:										

Current Medication:	**Dose:**	**How often:**	**Current Medication:**	**Dose:**	**How often:**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Previous Surgeries: _____

Previous Foot &/or Ankle Surgeries: _____

Previous Hospitalizations: _____

Foot &/or Ankle Related Chief Complaint: _____

Recent X-Rays/MRI of the Foot &/or Ankle: ☐ No ☐ Yes Date: _____

Family History

Father: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Thyroid Disease ☐ Coronary Artery Disease ☐ Rheumatoid Arthritis ☐ Bunions ☐ Ingrown Nails ☐ Other: _____

Mother: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Thyroid Disease ☐ Coronary Artery Disease ☐ Rheumatoid Arthritis ☐ Bunions ☐ Ingrown Nails ☐ Other: _____

Personal Information

Employer: _____ **Occupation:** _____

How much are you on your feet at work?: ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ 2/3 days per week ☐ Daily

Type of exercise: _____ **Height** _____ **Weight** _____ **Shoe size** _____

Do you smoke: ☐ No ☐ Yes Packs/day: _____ **Years:** _____ **Previous smoker: ☐ No ☐ Yes Packs/day:** _____ **Year quit:** _____

Alcoholic Beverages? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational Drugs? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

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OFFICE PRIVACY PRACTICE POLICY

NOTICE OF PRIVACY PRACTICE:

HIPPA (Health Insurance Portability and Accountability Act) regulations require us to provide the patient or their representative a copy of our Notice of Privacy Practice **upon request** and for you to sign and acknowledge receipt of this brochure.

ACKNOWLEGMENT - I have received a copy of the Notice of Privacy Practice.

_____	_____	_____
Print Patients Name	Patients Signature (if minor, parents signature required)	Date

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO 3RD PARTY:

Please list parents and any personal family member or friends who are authorized to call the office to make or change appointments or if they have any billing questions. If no one is listed, we will assume only you are authorized to make any changes. Personal and medical information are automatically authorized for insurance companies and doctors in an effort to coordinate care.

_____	_____	_____
(NAME)	(CONTACT #)	(RELATIONSHIP)

REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATIONS

You may request to receive confidential communications involving your protective health information (PHI) by an alternative means or alternative addresses. We may not ask you the reason for your request. We will accommodate all reasonable requests. If you make a special request, you must give an alternative address or the other method of contacting you (phone number, mail etc.). Please specify how or where you wish to be contacted:

_____

_____

ELECTRONIC DEVICE POLICY:

In order to protect the privacy of **ALL** patients we kindly request that you and anybody with you comply with our Electronic Device Policy. Patients and visitors are prohibited from using their electronic device(s) while in our office. Photographing and recording any individual(s) or any aspect of the Facility surroundings is strictly prohibited.

ACKNOWLEDGMENT

I have read the Notices and Policies stated above. I understand and I am in agreement with all the notices and policies.

_____	_____
Patients Signature (if minor, parents signature required)	Date

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FINANCIAL POLICY

CASH PATIENT

Full payment must be made at the time of service, unless there is prior financial arrangement made with the billing office.

PRIVATE INSURANCE / PPO INSURANCE

Insurance is a contract between you and your insurance company. Patients should contact their plans to confirm Doctor is in-network and clarifications of benefits prior to service rendered. _____ initial here.

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. Although we are not a party to this contract, **as a courtesy**, we will bill your insurance carrier, provided current insurance information is given to us before services are rendered. All applicable co-payments and/or deductibles are to be paid at the time of service. Any co-insurance amount the insurance company deems patient responsible is due upon receipt of your statement. All balances will be collected prior to scheduling your next appointment. We do not accept monthly payments. However, we do accept Care Credit financing and all major credit cards. Again, our office is not a party to your insurance contract, therefore; we will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, etc., other than to supply information as necessary.

MEDICARE

We are providers with Medicare, which means we will adjust the difference between what is billed to Medicare and what they allow. HOWEVER, the patient is responsible for their deductible and the 20% that Medicare does not pay. This amount will be expected within thirty days, unless you have a secondary insurance. We will be happy to bill your secondary insurance carrier for the 20%, if proper insurance information is given; however, you will be responsible for this amount if your insurance does not pay in a timely manner.

STATEMENTS

Our office will send an initial invoice with any outstanding balances. If additional statements are sent out in an effort to collect a past due balance, we will add an $5.00 re-statement fee per statement, after the initial invoice. As stated above, any amount the insurance company deems patient responsible is due upon receipt of your statement.

24-HOUR NOTICE

In order to avoid a **$50 cancellation** fee, our office kindly requests a 24 hour notice.

ACKNOWLEDGMENT

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered.

I have read the Financial Policy stated above. I understand and I am in agreement with the policy.
I agree to assign insurance benefits to Jeri M. Gruenes, DPM whenever necessary.

Patients Signature (if minor, parents signature required) Date