SAN JOSE PODIATRIC SURGERY & WOUND CENTER
200 JOSE FIGUERES AVE SUITE 275
SAN JOSE CA 95116
PATIENT REGISTRATION

Today's Date:	**Primary Care Physician:**

PATIENT INFORMATION

Patient's Last Name:	**First Name:**	**Middle Initial:**	**Title:**	**Birth Date:**	**Age:**	**Sex:**

PATIENT HISTORY

Reason for Visit

What brings you to the office today?

If this was an accident or injury:

Where did it occur?

Was this work related?

When did it occur?

How did it occur?

Please describe any previous treatment and care you have received for this problem.

Have you ever seen a podiatrist for this or any other problem? Please Explain.

Vitals / Pain Assessment / Podiatric History

Height____Weight____ Last Known Blood Pressure_____ Shoe Size _____

Indicate your level of pain on a scale of 1-10.

(10 = worst pain imaginable)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Check the symptoms that best describe your problem.

☐Sharp Pain ☐ Dull Pain ☐Stiffness ☐Instability ☐Swelling

☐Numbness ☐ Other:_____

Are your symptoms getting:

☐Better Gradually ☐ Better Rapidly

☐Worse Gradually ☐Worse Rapidly

What improves your symptoms?

☐Ice ☐Rest ☐ Heat ☐Pain Medication

☐Other:_____

Does your foot pain limit your desired activity?

☐Yes ☐No

Have you ever had any other foot problems?

☐Yes ☐No

If so, please explain:_____

Allergies

Are you allergic to any of the following? ☐IHave No Known Allergies

☐Penicillin ☐Sulfa ☐Erythromycin ☐Aspirin

☐ Contrast dye ☐Shellfish ☐Iodine ☐Latex

☐ Anti-inflammatories (NSAIDS) ☐ Local Anesthetics (Novacaine)

☐ Nickel / Metal ☐ Lactose ☐ Egg White ☐Adhesive tape

☐ Other: _____

Explain reaction to each:

Medications

Are you currently taking any blood thinners?

☐Yes ☐No Name:_____

What medications are you currently taking? (Please include over the counter and herbal medications and vitamins)

Name	Dosage	Frequency

Past Medical History

Have you ever had any of the following?

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis / Joint Disorder
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Back Problems
- ☐ Blood/ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes (Circle I **OR** II)
- ☐ Depression
- ☐ DVT (Blood Clot)
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis (Circle A /B/ C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Immune Disorder
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Lung/Respiratory Disease
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Neuropathy
- ☐ Open Sores
- ☐ Osteoporosis/penia
- ☐ Peripheral Vascular Disease
- ☐ Polio
- ☐ Restless Leg Syndrome
- ☐ RSD (Reflex Sympathetic Dystrophy
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Stomach Ulcer / GERD / Acid Reflux
- ☐ Thyroid Disorder
- ☐ Tuberculosis

Please further explain all of the above marked condition or any other conditions you have that are not listed above:

_____

_____

_____

Woman Only

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Hospitalizations & Surgeries

Reason	Date

Review of Systems

Please mark all that apply:

General: ☐ Weight Gain/Loss ☐ Change in Appetite ☐ Fever ☐ Chills ☐ Fatigue

Head: ☐ Headaches / Migraines ☐ Vertigo / Dizziness

Ears: ☐ Discharge ☐ Ringing in Ears ☐ Infection ☐ Pain

Eyes: ☐ Blurred Vision ☐ Watery Eyes ☐ Itchiness

Nose/Throat: ☐ Sinus Infection ☐ Drainage / Discharge ☐ Sore Throat ☐ Mass

Cardiovascular: ☐ Palpitation ☐ Chest Pain ☐ Calf Pain w/walking ☐ Cold Feet

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Cough

GI: ☐ Pain ☐ Bleeding/Ulcers ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting

GU: ☐ Incontinence ☐ Urgency ☐ Frequency ☐ Painful Urination ☐ Bleeding

Skin: ☐ Discoloration ☐ Itching/Burning ☐ Bruising ☐ Palpable Mass

Endocrine: ☐ Polyuria (increased urination) ☐ Polyphagia (increased eating)

Musculoskeletal: ☐ Weakness ☐ Joint Pain ☐ Muscle Ache

Neurological: ☐ Numbness ☐ Paralysis ☐ Tremor ☐ Sensory Disturbance

Psychiatric: ☐ Anxiety ☐ Depression ☐ Hallucinations

Family Medical History

Has anyone in your family had any of the following conditions? If so, mark the box and state who, and if possible further describe the condition.

- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis: Type_____
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer: Type_____
- ☐ Depression
- ☐ Diabetes (Circle I **OR** II)
- ☐ DVT (Blood Clot)
- ☐ Epilepsy
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease / Coranary Artery Disease
- ☐ Hepatitis (Circle A/B/C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Psychiatric Disorder
- ☐ Osteoporosis/penia
- ☐ Stroke
- ☐ Thyroid Disorder

Social History

Have you ever smoked?

☐ Yes ☐ No If so, # of years_____ #packs/day_____

Do you smoke now?

☐ Yes ☐ No If so, # of packs/day_____

Do you use recreational drugs?

☐ Yes ☐ No If so, Types _____ #times/week_____

Do you drink alcohol?

☐ Yes ☐ No If so, # of times/week_____

Do you drink caffeine?

☐ Yes ☐ No If so, # of times/day_____

Do you exercise?

☐ Yes ☐ No If so, type_____ # of times/week_____

What type of shoes do you normally wear?

☐ Flat ☐ Heels ☐ Boots ☐ Loafers ☐ Oxfords

☐ Sandals ☐ Sneakers ☐ Other:_____

Please provide any other pertinent information in the box below:

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. 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.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____

SIGNATURE

_____

DATE

NOTICE OF PHOTOGRAPHY TO DOCUMENT CARE:

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that San Jose Podiatric Surgery & Wound Center will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in San Jose Podiatric Surgery and Wound Center's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

_____

SIGNATURE

_____

DATE

SAN JOSE PODIATRIC SURGERY & WOUND CENTER

200 JOSE FIGUERES AVE SUITE 275

SAN JOSE CA 95116

PATIENT REGISTRATION

Today's Date:			Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name: First Name: Middle: Marital Status:

Birth Date:	Age:	Sex:	Address(NO PO BOX):

Social Security Number:	Home Phone Number: May We Leave a Message? YES / NO	Cell Phone Number: May We Leave a Message? YES / NO
Occupation:	Employer:	Email Address:

How did you hear about us? / Who were you referred by?:

Other family members seen here:

Primary Language: Race: Ethnicity:

Do you have a legal guardian or healthcare power of attorney? YES / NO (If YES please provide the name / relationship and phone number for this person below)

Pharmacy (Location / Phone Number):

Is there a family member or other person you would like for us to share your medical information with? YES/ NO (If YES please provide the name / relationship / phone number for this person)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible for Bill:	Birth Date:	Address (if different):	Home Phone Number:
Occupation:	Employer:	Employer Address:	Employer Phone Number:

Please indicate primary insurance:

Subscriber's Name:	Subscriber's S.S. Number:	Subscribers DOB:	Group Number:	Policy Number:	Specialist Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's Name and SSN:	Group Number:	Policy Number:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone Number:	Work Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize San Jose Podiatric Surgery and Wound center or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

San Jose Podiatric Surgery & Wound Center
200 Jose Figueres Ave Suite 275
San Jose CA 95116
P: 408-262-1188 F: 408-599-3182

Patient Acknowledgement of Receipt of Privacy Practices Notice

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information
- My privacy rights with regard to protected health information
- This office's obligations concerning the use and disclosure of my protected health information

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact Dr. Sara Karamloo in writing at 200 Jose Figueres Ave Suite 275 San Jose Ca 95116.

You may also contact the Secretary of the U.S. Department of Health and Human resources with any concern regarding our privacy and security policies and procedures.

Patient or Personal Representative

Signature: _____ Date: _____

Name (Print): _____

Relationship to Patient:_____

For Office Use Only

We made a good faith effort to obtain an acknowledgement of _____'s receipt of our *Notice of Privacy Practices.* In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- Patient refused to sign (date of refusal)
- Communication barriers prohibited obtaining an acknowledgement
- An emergency situation prevented us from obtaining an acknowledgement
- Other

Attempt was made by: _____

San Jose Podiatric Surgery & Wound Center
Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. If you have a co- payment we are required by our contract to collect it at the time of your visit. We will accept VISA, MasterCard, American Express, cash or personal check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible. We will accept payment based on the insurance company's allowable fee schedule and the contract your group has with that carrier. Any allowable balances are the responsibility of the patient or guarantor and are due in full upon receipt of the statement. If you have a secondary or supplemental insurance you must relay this to us to prevent disruptions in payments.

- If you have insurance coverage with a plan with which we do not have a prior agreement (Out of Network Provider), we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service. If Out of Network status is not identified at the time of service you will be billed for the treatment and your payment is due upon receipt of the statement.

- 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. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- Durable Medical Equipment (e.g. post operative shoes / orthotics / night splints / camwalkers) or any supplies dispensed during that visit that have a dedicated HCPCS code will be billed to your insurance company. If they are deemed not a covered benefit, you are responsible to pay the cost for the goods dispensed in full. Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this billing notice.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- For large balances we may consider a reasonable monthly payment. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.

- There is a service fee of $25.00 for all returned checks and missed appointments, not canceled 24 hours before. Your insurance company does not cover these fees.

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. I authorize all payments to be made directly to my provider on my behalf for any services or supplies furnished by my doctor and for my doctor or his / her representative to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies, as well as Medicare / MediCal, in order to determine benefits payable for related services, now or in the future.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____