ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Welcome to Lodi Podiatry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you and maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Phone No. _____ Cell Phone No. _____

Mailing Address _____ Email _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: Please check one ○ American Indian or Alaska Native ○ Asian ○ Black or African American
○ Hispanic ○ Native Hawaiian or Other Pacific Island ○ White ○ Not Specified

Spouse or Guardian Name _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who may we thank for referring you? _____

Family Doctor _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____
(Does not reside with you)

Primary Insurance

Person Responsible for Account _____
Last Name First Name Inital

Relation to Patient _____ Birth Date _____ Soc. Sec.# _____

Address _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Subscriber # _____ Group # _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address (if different from patient) _____ Soc. Sec.# _____

City _____ State _____ Zip _____ Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Subscriber # _____ Group # _____

Please complete both sides.

Patient Podiatric and Health Information

Family Physician _____ Last Visit _____

What is the nature of your foot problem? _____

_____

Height _____ Weight _____ Shoe Size _____

Do you have back pain? Y☐ N☐ Have you had previous foot/ankle surgery? Y☐ N☐ Date & Type _____

Do you use tobacco products? Y☐ N☐ If yes, what amount daily? _____

Medical History

Check (✓) if you have had any of the following:

- ☐ Aids/HIV
- ☐ Arthritis, Rheumatisim
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulatory problems
- ☐ Cramps/Numbness in feet or legs
- ☐ Diabetes
- ☐ Gout
- ☐ Heart trouble
- ☐ Hepatitis or Jaundice
- ☐ High blood pressure
- ☐ History of drug abuse
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Swelling of feet or ankles
- ☐ Transfusions
- ☐ Varicose veins
- ☐ Pacemaker
- ☐ Other _____

Are you allergic or sensitive to:

- ☐ None
- ☐ Adhesive Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Other _____

List medications you are currently taking, if any, including vitamins or herbs:

_____ _____

_____ _____

_____ _____

Pharmacy Name _____ Phone Number _____

Do you take oral contraceptives? ☐ Y ☐ N

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to Thomas G. Shock, DPM, Kevin I. Stroh, DPM or Alex J. Curfman, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on,all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

MEDICARE PATIENTS **Medicare Signature on File** MUST SIGN BOTH SECTIONS

Medicare Signature on File I request that payment at authorized Medicare benefits be made on my behalf to Thomas G Shock, DPM, Kevin I. Stroh, DPM or Alex J. Curfman, DPM for any services furnished me by the listed Physician/Supplier I authorize any holder of Medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap Insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim If "other health insurance" to indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non covered services Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature _____ _____ Date _____

Dear Patient; name please, lest we mix them up, Whoops! _____

In the rapidly changing environment of medicine, there is more, and more data gathering, a requirement for a complete and thorough medical record. Below, we will need your assistance in again obtaining such mandated information; trying to make it as simple and straight-forward as possible. New regulations as of January 1, 2015; require A minimum of data entry into our new computer system. Thank you for your cooperation.

Past Medical History: (Please just circle those that apply..... We will expand upon the history as deemed necessary)

Alzheimer's disease Arthritis Asthma Back Pain Cancer COPD

Cardiovascular disease Depression/Anxiety Diabetes Deep Vein Thrombosis

Fibromyalgia GERD Gout Hepatitis Hypertension Kidney Disease

Liver Disease Lung Disease Multiple Sclerosis Neck Pain Neuropathy

Obesity Parkinson's Disease Seizures Sleep Apnea Stroke

Thyroid Disease Urinary Infections *addn:* _____

Past Surgical History:

C-Section Gallbladder Surgery Joint Replacement Surgery (hip, knee, shoulder)

Hysterectomy Kidney Removal Knee Arthroscopy Hernia Surgery

Low Back Surgery Neck Surgery Shoulder Surgery Carpal Tunnel Surgery

Foot/Ankle Surgery _____ *addn:* _____

Social History:

Marital status: Married Single Widowed Divorced Separated

Whom do you live with? Husband Wife Alone Children Significant Other Parents

How many children? _____

Employment: Employed Retired Unemployed Disabled

Occupation: (Current /or Former): _____

Smoking status: Current smoker Non-smoker Former Smoker

- If applicable, how much to you smoke per day?
- Less than 5 cigarettes per day
- One half pack per day
- One pack per day
- More than one pack per day

Do you drink caffeinated beverages? (Cola, Coffee, or Tea)

Yes No approximate number per day: _____

Lastly, if our chart is to be complete, to the scrutiny of an insurance/regulatory audit; it must contain a family history with the following criteria.....

We are trying to make this as quick, and easy is possible. All we are looking for is a familial history, medical history of either father or mother. We don't want to make this too complex, if you would, just circle a positive history and put either a " F " for *father* next to the disease/condition; or a " M " for *mother*. Trust me, we don't necessarily like this anymore than you do. However, there are expectations for a complete chart, and it is our policy to attempt to abide by things as reasonably as possible. We, both you and us; only have to do this once, or until the rules change!

* Immediate Family Only *

Now for an example: Rheumatic Fever ADHD Macular Degeneration

Now you see what we are looking for, we have to then input all this, and everything else, into the computer! Thanks for your assistance.

Angina Ankylosing Spondylitis Autism Bipolar Disorder Celiac Disease

Crohn's disease Dementia Depression Diabetes (Type 1) Emphysema

Diabetes (Type 2) Intestinal Ulcerations Glaucoma Heart Attack Hypertension

Hyperlipidemia Hyperthyroidism Kidney Stones Melanoma Migraines

Narcolepsy Osteoarthritis Osteoporosis Psoriasis Rheumatic Fever

Rheumatoid Arthritis Schizophrenia Scoliosis Stroke Vitiligo

Now for the cancers: Bladder Cancer Breast Cancer Colorectal Cancer

Liver Cancer Ovarian Cancer Pancreatic Cancer Prostate Cancer

Thyroid Cancer Uterine Cancer