

PODIATRIC REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: ___ M ___ F Age _____ Birthdate _____

Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____

How did you hear about us?

2

CONTACT INFORMATION

Email _____

Telephone Information:

Home _____ Work _____ Ext _____

Mobile _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Telephone Information:

Home _____ Work _____

3

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes ___ No ___

Subscriber Name _____

Birthdate _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

4

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship Date

5

PODIATRIC HISTORY

What is the chief complaint for which you to be treated (Include foot, ankle, knee hip, thigh complaints)

Have you ever been to a Foot Doctor before? ___ Yes ___ No

Name _____

Last Visit _____

Is there any personal or family history of diabetes? ___ Yes ___ No

Cigarette/Tobacco use _____

Years Smoked _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

Ankle Pain ___ Athlete's Foot ___

Bunions ___ Corns & Callouses ___

Numbness in Feet or Legs ___

Flat Feet ___ Foot /Leg Cramps ___

Heel Pain ___ Ingrown Toenails ___

Plantar's Warts ___ Tired Feet ___

Swelling in Ankles or Feet ___

6 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	___	___	Diabetes	___	___	Psychiatric Care	___	___
Allergies to Anesthetics	___	___	Ear Problems	___	___	Radiation Treatment	___	___
Allergies to Medicine or Drugs	___	___	Epilepsy	___	___	Rash	___	___
Anemia	___	___	Eye Problems	___	___	Respiratory Disease	___	___
Angina	___	___	Fainting	___	___	Rheumatic Fever	___	___
Arthritis	___	___	Foot or Leg Cramps	___	___	Shortness of Breath	___	___
Artificial Heart Valves or Joints	___	___	Gout	___	___	Sinus Problems	___	___
Asthma	___	___	Headaches	___	___	Special Diet	___	___
Back Problems	___	___	Heart Disease	___	___	Stroke	___	___
Bleeding Disorders	___	___	Hemophilia	___	___	Swelling in Ankles, Feet	___	___
Cancer	___	___	Hepatitis or Jaundice	___	___	Swollen Neck Glands	___	___
Chemical Dependency	___	___	High Blood Pressure	___	___	Tired Feet	___	___
Chest Pain	___	___	Kidney Problems	___	___	Tuberculosis	___	___
Chronic Diarrhea	___	___	Liver Disease	___	___	Ulcers	___	___
Circulatory Problems	___	___	Low Blood Pressure	___	___	Varicose Veins	___	___
Height _____			Nervous Problems	___	___	Venereal Disease	___	___
Past Surgeries _____			Phlebitis	___	___	Weight Loss, unexplained	___	___
			Weight _____					

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ___ Yes ___ No

If yes, please explain _____

7 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins.

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ___ Yes ___ No

8 ALLERGIES

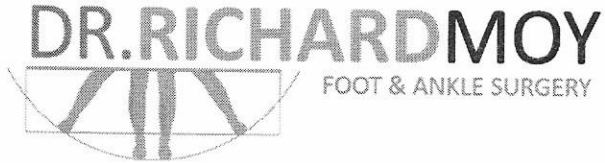
___ Adhesive/Tape	___ Local
___ Anticoagulant	___ Novocaine
___ Therapy	___ Penicillin
___ Aspirin	___ Seafoods
___ Codeine	___ Sulfa
___ Demerol	___ Iodine

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____



29300 Portola Parkway, Ste B
Lake Forest, Ca 92630
P: (949)837-3338
F: (949)716-2725
DrMoy.com

RICHARD R MOY DPM INC
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of the "Notice of Privacy Practices", as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient's Signature

Date



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Insurance Authorization

I, the undersigned, certify that I have insurance coverage and authorize Dr. Richard R Moy to have all claims processed on my behalf under the insurance benefit plan level, either PPO or Out-of-Network.

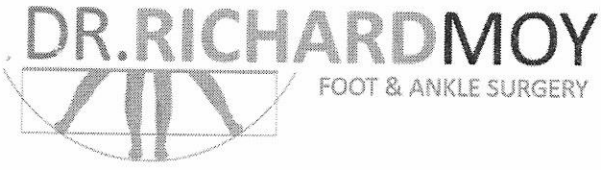
I, certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. Moy all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand that I am financially for any co-payment, co-insurance, deductible and other charges whether or not paid by insurance.

Patient Name (Printed)

Patient or Responsible Party Signature

Date



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Cost for Medical Records

We charge a fee for medical records to cover the costs of copying, mailing and/or other supplies associated with your request. Upon receiving your request, we will inform you of the fee.

1-10 pages	\$10.00
Additional pages postage <i>*rates vary based on size of medical record</i>	\$0.50 per page
X-rays or diagnostic imaging	\$10.00

Patient Name (Printed)

Patient or Responsible Party Signature

Date



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History of Foot Problems

Patient Name: _____

Date: _____

ONSET

1. When did the pain start? *e.g. 1 week, 1 month, 1 year*

NATURE OF PAIN:

2. What kind of pain or pains are you having? *e.g. sharp, dull, shooting, stabbing aching, radiating, diffuse, constant, intermittent*

LOCATION:

3. Where is the pain? *e.g. right or left foot, toes, top/bottom of foot, arch, heel, ankle, toenails*
4. What symptoms do you have? *e.g. swelling, redness, bruising, burning, itching, numbness, discolored nails, skin flaking, bumps, tiredness, cramping*

PAST TREATMENT:

5. Self – What have you done to alleviate pain? *e.g. rest, ice, medication, change activities, change shoes*
6. Professional – Have you seen anyone for this problem? What did they do for you? What advice or treatment was given?

DR. RICHARD MOY



FOOT & ANKLE SURGERY

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Lake Forest, Ca 92630

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FOOTWEAR:

7. What shoes can you wear? *e.g. tennis shoes, heels, boots*

8. What shoes do you avoid and why? *e.g. tennis shoes, boots, heels*

WORK/RECREATION

9. How has this affected your work, if at all?

10. How has this affected your recreational activities? *e.g. stopped running, skiing, walking, etc.*

Patient or Responsible Party Signature

Date

Out of Network Provider

Provider Name : Richard R May DPM
Date of Service: _____

Out of Network Provider Consent Form

Effective July 1, 2017 Pursuant to the Assembly Bill No. 72 Bonta. Health care coverage: Out of network coverage - Providers are required to obtain written consent from subscribers to bill their Insurance carrier for out of network services provided. This will allow an exception from this provision for the provider to get reimbursed at the out of network rate and not be deemed at an "In-network cost-sharing amount".

Bill 72 States, "If nonemergency services are provided by a noncontracting individual health professional consistent with subdivision (c) of Section 1371.9 to an enrollee who has voluntarily chosen to use his or her out-of-network benefit for services covered by a plan that includes coverage for out-of-network benefits, unless otherwise agreed to by the plan and the noncontracting individual health professional, the amount paid by the health care service plan shall be the amount set forth in the enrollee's evidence of coverage. This payment is not subject to the independent dispute resolution process described in Section 1371.30."

The Provider (*such as Professional or Anesthesiologist*) listed above is out of network with your insurance carrier and therefore requires your written consent to bill your insurance company for the out of network services being provided.

By signing below I'm acknowledging that I have read and understand the information written above. I have been advised prior to service that the provider (*such as Professional or Anesthesiologist*) is out of network with my insurance carrier.

My signature below authorizes the out of network provider (*such as Professional or Anesthesiologist*) to bill my insurance carrier and apply my out of network benefits.

Patient
Signature: _____

Date
Signed: _____

A copy of the completed form may be requested by the patient, and the original will be placed in the medical file.