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
AIDS/HIV		
Allergies to Anesthetics		
Allergies to Medicine or Drugs		
Anemia		
Angina		
Arthritis		
Artificial Heart Valves or Joints		
Asthma		
Back Problems		
Bleeding Disorders		
Cancer		
Chemical Dependency		
Chest Pain		
Chronic Diarrhea		
Circulatory Problems		
Diabetes		
Ear Problems		
Epilepsy		
Eye Problems		
Fainting		
Foot or Leg Cramps		
Gout		
Headaches		
Heart Disease		
Hemophilia		
Hepatitis or Jaundice		
High Blood Pressure		
Kidney Problems		
Liver Disease		
Low Blood Pressure		
Nervous Problems		
Phlebitis		
Psychiatric Care		
Radiation Treatment		
Rash		
Respiratory Disease		
Rheumatic Fever		
Shortness of Breath		
Sinus Problems		
Special Diet		
Stroke		
Swelling in Ankles, Feet		
Swollen Neck Glands		
Tired Feet		
Tuberculosis		
Ulcers		
Varicose Veins		
Venereal Disease		
Weight Loss, unexplained		

Height _____ Weight _____

Past Surgeries

_____

_____

_____

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 exlain _____

_____

_____

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
__ Anticoagulant Therapy
__ Aspirin
__ Codeine
__ Demerol
__ Local
__ Novocaine
__ Penicillin
__ Seafoods
__ Sulfa
__ 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 _____

DR.RICHARDMOY
FOOT & ANKLE SURGERY

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 **rates vary based on size of medical record*	$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?

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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, it 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.