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	__	__
			Nervous Problems	__	__	Venereal Disease	__	__
			Phlebitis	__	__	Weight Loss, unexplained	__	__

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

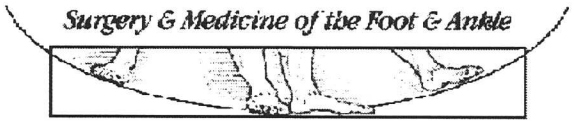
Other_____

_____

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_____



Richard R Moy, D.P.M. Inc

29300 Portola Parkway, Ste B
Lake Forest, Ca 92630
(949) 837-3338 Phone
(949) 716-2725 Fax

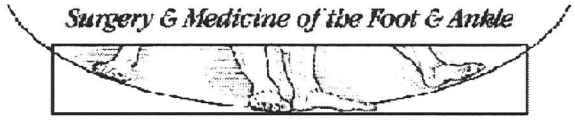
Cost for Medical Records

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 $0.50 per page
Postage (rates vary based on size of medical record)
X-Rays or Dignostic Imaging $10.00

Patient Signature: _____

Patient Name: _____ Date: _____



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PATIENT CONTACT INFORMATION FORM

Patient Name: _____ DOB: _____

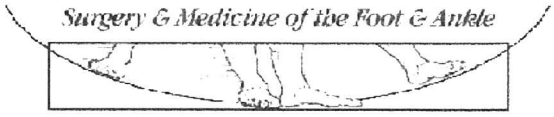
Cell Number: _____ Home Number: _____

May we leave a message on your cell number: **YES/NO (Circle One)**

May we leave a message on your home number: **YES/NO (Circle One)**

Email address: _____

May we contact you by email: **YES/NO (Circle One)**



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INSURANCE AUTHORIZATION

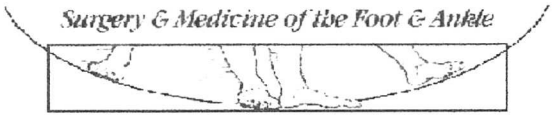
I, the undersigned, certify that I have insurance coverage and authorize Dr. Richard R Moy to have all claims processed on my behalf under the insurance benefit plan level, either PPO or Out-of-Network.

I, certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. _____ 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 financially responsible 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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HISTORY OF FOOT PROBLEMS

Patient Name: **Date:**

1. Onset:
   When did the pain start? eg: 1 week, 1 month, 1 year

2. Nature of Pain:
   What kind of pain or pains are you having? eg: sharp, dull, shooting, stabbing, aching, radiating, diffuse, constant, intermittent

3. Location:
   Where is the pain? eg: right or left foot, toes, top or bottom of foot, arch, heel, ankle, toenails

4. What symptoms do you have? eg: swelling, redness, bruising, burning, itching, numbness, discolored nails, skin flaking, bumps, tiredness, cramping

5. Past Treatment
   Self: What have you done to alleviate pain? (rest, ice, medication, change activities, change shoes)

Professional: Have you seen anyone for this problem? What did they do for you? What advice or treatment was given?

6. Footwear
   What shoes can you wear? eg: tennis shoes, heels, boots

What shoes do you avoid and why? eg: tennis shoes, boots, heels

7. Work/Recreation
   How has this affected your work, if at all?

8. How has this affected your recreational activities? eg: stopped running, skiing, walking, etc

_____

Patient Signature