

NEW PATIENT INFORMATION**TODAY'S DATE:** _____

Patient's Name: _____ Age _____ Birth Date _____

Home Address _____ City: _____ Zip Code: _____

Cell Phone _____ Home Phone _____ E-mail _____

Marital Status: [] Married [] Single [] Divorced [] Separated [] Widow/er [] Minor Sex: [] Male [] Female [] Non-binary

Patient or Parent Driver's License # _____ SS # _____

Employed By _____ How Long? _____ Occupation _____

Work Address _____ City: _____ Zip Code: _____

Work Phone _____ Spouse/Partner/Parent Name: _____

REFERRAL: Whom may we thank for referring you to our Office _____

How did you learn about our office: [] Google [] Yelp [] Website [] Insurance Listing [] _____

PAYMENT METHOD: [] Cash [] Check [] Credit Card [] Medicare [] Insurance**PRIMARY INSURANCE COMPANY:** _____

Name of Insured _____ SS # _____ Date of Birth _____

Relationship to patient _____ Employed By _____

Work Address/City/Zip _____ Work Phone _____

SECONDARY INSURANCE COMPANY: _____

Name of Insured _____ SS # _____ D.O.B. _____

Relationship to patient _____ Employed By _____

Work Address/City/Zip _____ Work Phone _____

REASON FOR VISIT: [] Injury [] Job Injury [] Medical Problem [] Second Opinion [] Consultation

Describe medical issue [] Both [] Right [] Left Injury Date or Problem Onset _____ Time _____

How is the medial problem affecting you – previous treatments? _____

Past / Current Podiatrist _____ City _____ Last Visit _____

PHARMACY: _____ Address _____ Phone: _____

FINANCIAL POLICY: Initial: [X] _____ I am financially responsible for all charges if not paid by my insurance. We will bill your insurance as a courtesy but if the insurance does not pay, you will be responsible for payment. Payment of non-covered medical care, deductibles and co-pays are due at the time of service. I agree to a \$25.00 returned check charge. I agree accounts 60 days past due will be charged an 18% annual interest rate until paid.

MEDICAL RECORDS RELEASE / ASSIGNMENT OF BENEFITS: I hereby authorize this office to release any necessary information for the payment of insurance claims and assign insurance payments directly to this office otherwise payable to the insured. I agree to allow a copy of this authorization to be used in place of an original. I agree to notify the office 24 hours in advance to change an appointment or agree to be charged \$25 for office visits or \$50 for procedures.

Patient, Parent, Guardian Signature _____ **Date** _____

PLACENTIA-LINDA
FOOT AND ANKLE GROUP



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HEALTH HISTORY QUESTIONNAIRE

Name _____ Birth Date _____ Today's Date _____

Age _____ Height _____ Weight _____ Shoe Size _____ Dominant Hand []Right []Left

CHIEF COMPLAINT AND ITS HISTORY: Describe what is wrong, when did the problem begin, what foot, location, how has it progressed and what happens at night or in the morning? _____

Quality of Pain: []Burning []Throbbing []Sharp []Dull []Aching []Stabbing **Pain Severity:** 1 to 10(10 unbearable) _____
Pain Duration []Constant []Infrequent **Pain Timing** []AM []PM []All-day **Pain Aggravation** -What increases or decreases pain? _____

What other foot problems do you have / had? _____

OTHER CURRENT MEDICAL CARE: Please list your Regular Doctor and all other current health care providers:

Illness or Medical Problem	Health Care Provider	City of office	Phone	Dates of Treatment
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DIABETIC: Type []1 or []2 Do you test daily []Yes []No. Typical AM Glucose? _____ Last Hg-A1c lab test? _____

LAST PHYSICAL: When and who was your doctor? _____

PAST MEDICAL HISTORY: []Diabetes, []Diabetic Foot Ulcers, []AIDS / HIV, []Hepatitis, []Heart Attack, []Irregular Heart Beat, []Heart Murmurs []Mitral Valve Prolapse, []Congestive Heart Failure, []Stroke, []Hypertension, []Convulsions, []Emphysema, []Seizures, []Cancer, []Asthma []Rheumatoid Arthritis, []Bleeding problems, []Sickle-cell Disease, []Blood Transfusions

MAJOR SURGERIES, ILLNESSES, INJURIES, AND HOSPITALIZATIONS:

Year	Operation, Injury, Illness, Hospitalization	Doctor/Hospital/City	Residual Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT ALLERGIES: List any reactions to any medications, tapes, soaps, latex rubber, etc.

[]I am **PENICILLIN ALLERGIC** - it causes []Hives []Shortness of breath []Anaphylaxis reactions.

[]Other Allergies _____

CURRENT MEDICATIONS: List the type and dosage of all medications including aspirin, birth control, herbs and vitamins.

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

SOCIAL HISTORY: Pregnancy: Are you pregnant? []No []Yes Birth control method? _____

Tobacco Use: []No []Yes- Packs per day _____ How many years? _____ When did you quit? _____

Alcohol: []No []Yes - How much each week _____ Recreation Drugs: []No []Yes _____

Living Situation: Where and who do you live with? _____

Emotional: Describe any emotional problems _____

Job Description / work activities _____

Exercise: Describe type and frequency _____

HEALTH HISTORY QUESTIONNAIRE - Continued

NAME _____ Today's Date _____

FAMILY HISTORY:

	If Living	at Death	Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

DID ANY BLOOD RELATIVES HAVE THE FOLLOWING ILLNESSES:

Diabetes _____	Migraine Headaches _____
Bunions _____	Cystic Fibrosis _____
Flat Feet _____	Birth Defects _____
Breast Problems _____	Epilepsy _____
High Blood Pressure _____	Glaucoma _____
Heart Disease _____	Rheumatoid Arthritis _____
Stroke _____	Multiple Sclerosis _____
Cancer _____	Colitis _____
Asthma/Emphysema _____	Alcoholism _____

INTERNATIONAL TRAVEL / LAB TESTS: Where & when did you travel? _____

Vaccines Received: [] Covid [] Measles [] Pneumococcus [] Typhoid [] Yellow Fever [] Polio [] Cholera [] Hepatitis A ___ B ___

Last Tetanus _____ Last Chest X-ray _____ Last Blood Test _____ Last TB test _____ [] Pos. [] Neg. [] BCG

REVIEW OF BODY SYSTEMS: Please list the date or year of onset and if the condition occurs rarely or frequently.

Year Onset	Rare[R] or Frequent[F]	Year Onset	Rare[R] or Frequent[F]	Year Onset	Rare[R] or Frequent[F]
CONSTITUTIONAL		GASTROINTESTINAL		SKIN / INTEGUMENT	
Weight Loss / Gain _____	_____	Stomach Nausea _____	_____	Rash / Condition. _____	_____
Weakness _____	_____	Abdominal Pains _____	_____	Keloid Problems _____	_____
Fatigue _____	_____	Vomiting _____	_____	Bruise Easily _____	_____
Fever _____	_____	Stomach Ulcer _____	_____	Sores Hard to Heal _____	_____
HEAD & NECK		Constipation _____	_____	Foot Fungus _____	_____
Headaches _____	_____	Diarrhea _____	_____	Toe Nail Problems _____	_____
Neck Pain _____	_____	Abdominal Pain _____	_____	Toe Nail Fungus _____	_____
Fainting Spills _____	_____	Appendicitis _____	_____	NEUROLOGICAL	
EYES		Appetite loss _____	_____	Loss of Memory _____	_____
Glasses or Contacts _____	_____	Excessive Thirst _____	_____	Neuropathy _____	_____
Blurred Vision _____	_____	Black/Bloody Stool _____	_____	Foot Numbness _____	_____
Cataracts _____	_____	Gallbladder Trouble _____	_____	Coordination issues _____	_____
Glaucoma _____	_____	Colitis _____	_____	Weakness/Paralysis _____	_____
EAR, NOSE, THROAT & MOUTH		GENITOURINARY		Muscle Weakness _____	_____
Hearing Problems _____	_____	Bladder Problems _____	_____	Muscle Spasms _____	_____
Loss of Balance _____	_____	Painful Urination _____	_____	PSYCHIATRIC	
Ringing in Ears _____	_____	Dark/Bloody Urine _____	_____	Nervousness _____	_____
Nose Bleeds _____	_____	Frequent Urination _____	_____	Mood Swings _____	_____
Sleep Apnea _____	_____	Prostate Trouble _____	_____	Depression _____	_____
Neck Artery Issues _____	_____	GYNECOLOGICAL		ENDOCRINE	
Dentures _____	_____	Post-menopausal _____	_____	Hot/Cold Intolerance _____	_____
Gum Problems _____	_____	Breast Problems _____	_____	Severe Thirst/Hunger _____	_____
CARDIOVASCULAR		Menstrual Problems _____	_____	Heavy Sweating _____	_____
Chest Pain _____	_____	MUSCULOSKELETAL		Thyroid Trouble _____	_____
Out of Breath Quickly _____	_____	Muscle Weakness _____	_____	HEMATOLOGIC / LYMPHATIC	
Sleep Sitting Up _____	_____	Back Pain _____	_____	Anemia _____	_____
Night Leg Cramps _____	_____	Scoliosis _____	_____	Anticoagulants _____	_____
Dizziness / Fainting _____	_____	Unequal Leg Length _____	_____	Jaundice Episodes _____	_____
Leg Blood Clots _____	_____	Knee Pain _____	_____	ALLERGIC / IMMUNOLOGIC	
Varicose Veins _____	_____	Walking Leg Cramp _____	_____	Measles / Rubella _____	_____
High Cholesterol _____	_____	Weak Ankles _____	_____	Polio _____	_____
RESPIRATORY		Foot Joint Pain _____	_____	Mumps _____	_____
Chronic Cough _____	_____	Swollen Ankles/Feet _____	_____	Scarlet Fever _____	_____
Coughing Up Blood _____	_____	Gout in the Foot _____	_____	Mononucleosis _____	_____
Shortness of Breath _____	_____	Flat Feet _____	_____	Allergic Anaphylaxis _____	_____

NOTICE OF PRIVACY PRACTICES (Standard Required Form)

I. **OUR LEGAL DUTY:** This notice describes how medical information about you may be used and disclosed and how you can get access to your information. Please review it carefully. The privacy of your medical information is important to this office and this protection became effective on April 14, 2003 through applicable federal and state laws. This notice will remain in effect until replaced by this office and will cover our privacy practices, our legal duties, and your rights concerning your protected health information. We reserve the right to change our privacy practices and the terms of this notice at any time as permitted by applicable law for all protected health information that we maintain, including medical information we created or received before we made the changes.

II. **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:** *We will use and disclose your protected health information about you for treatment, payment, and health care operations including the following examples of the types of uses and disclosures. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.*

1. **Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
2. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
3. **Health Care Operations:** We may use or disclose, as needed, your protected health information in order to conduct certain business information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
4. **Uses and Disclosures Based On Your Written Authorization:** Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.
5. **Others Involved in Your Health Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that is in your best interest based on our professional judgment to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care regarding your location, general condition or death.
6. **Marketing:** Your information will not be sold to a mailing list company by this office. We may use your protected health information to contact you with information about our office and treatment information or treatment alternatives that may be of interest to you and we may use a business associate to assist us in these activities. Unless the information that is provided to you is by a general newsletter or in person, you may opt out of receiving further such information by using the contact information listed below.
7. **Research:** We may use or disclose your protected health information for research purposes in limited circumstances.
8. **Public Health and Safety:** We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.



9. **Health Oversight:** We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit program, other government regulatory programs and civil rights laws.
10. **Abuse or Neglect:** We may disclose your protected health information, applicable federal and state laws, to a public health or a governmental entity or agency that is authorized by law to receive reports of child abuse or neglect if we believe that you have been a victim of abuse, neglect or domestic violence.
11. **Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse effects, product defects or problems deviations or to conduct post marketing surveillance, as required.
12. **Required by Law:** We may use or disclose your protected health information when we are required to do so by law such as from the U.S. Department of Health and Human Services or when authorized by worker's compensation or applicable state laws.
13. **Process and Proceedings:** We may disclose your protected health information to law enforcement officials or a court under certain circumstances in response to a court order, warrant or grand jury subpoena, administrative order, subpoena, discovery request or other lawful process.

III. PATIENT RIGHTS

1. **Access:** You have the right to get copies of your protected health information by making a request in writing to the contact person or the office address listed below. If you request copies, we will charge you twenty-five (25) cents per page and \$25 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee of \$35. If you want X-ray copies, we will charge you \$10 for each X-ray in your file or for those X-rays that you request to be copied in writing.
2. **Accounting of Disclosures:** You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations for the past six (6) years. This list of instances will document the date, the name of the person or entity, a description of what was disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, a \$35 charge will occur for each request.
3. **Restriction Requests:** You have the right to request in writing that we place additional restrictions on our use of the disclosure of your protected health information. We are not required to agree to these additional restriction, but if we do, we will abide by our agreement (except in an emergency). The agreement must be signed by the contact person for the office to be valid.
4. **Confidential Communication:** You have the right to request that we communicate with you about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.
5. **Amendment:** You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amended and to include the changes in any future disclosures of that information.
6. **Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form by contacting us using the information listed below.

IV. QUESTIONS AND COMPLAINTS: If you want a copy of our notice (or any subsequent revised notice) or more information about our privacy practice or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services and we will provide you with the address to file you complaint upon request. We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

V. ACKNOWLEDGMENT 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)	Parent or Authorized Representative (if applicable)	Date	Signature
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