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 0ffice _____
How did you find us? ☐Google ☐ Yelp ☐Website ☐Insurance Listing ☐Other_____

PAYMENT METHOD: ☐Cash ☐Check ☐Credit Card ☐Medicare ☐Insurance
PRIMARY INSURANCE:_____Name of Insured_____
SS #_____ Date of Birth _____ Relationship to Patient _____
Address/City/Zip_____Phone_____
SECONDARY INSURANCE: _____ Name of Insured _____
SS #_____ Date of Birth _____ Relationship to Patient _____
Address/City/Zip_____Phone_____

REASON FOR VISIT: ☐Wound Care ☐Injury ☐Job Injury ☐Medical Problem ☐Second Opinion ☐Consultation ☐EDD ☐Other_____

EMERGENCY CONTACT:_____ Related _____ Phone:_____

PHARMACY:_____ Address_____City:_____Phone:_____

FINANCIAL POLICY: 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 45 days past due will be charged an 18% annual interest rate until paid. **[X] Initial:** _____

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS & RESPONSIBILITIES: I or My Legal Representative hereby acknowledge the above standard privacy notices have been read. (A copy may be given to you upon request.) **[X] Initial:** _____

AUTHORIZATION TO COMMUNICATE YOUR MEDICAL INFORMATION Please list anyone who want to receive your protected health information and to what extent.

Name	Relationship	Extent Protected Health Information to share? All	Only Medical Records	Only Billing /Insurance
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐

MEDICAL RECORDS RELEASE / ASSIGNMENT OF BENEFITS / FEES: 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 understand the office uses a HIPPA compliant AI digital system to produce medical records. 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**_____

OC Center for Wound Healing & Foot Care
1275 N. Rose Drive, Suite 136, Placentia, CA 92870

Office: 714-528-3668
Fax: 714-528-0739
Info@Podiatry.Care

Mark Reed, DPM DABFAS FAPWCA

HEALTH HISTORY QUESTIONNAIRE

Name_____ **Birth Date** _____ **Today's Date** _____

Age _____ Height _____ Weight _____ Shoe Size _____ Dominant Hand: ☐Right ☐Left If Diabetic -- Last HgA1c_____

CHIEF COMPLAINT AND ITS HISTORY: Date of Onset: _____ Location: _____

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 What increases or decreases pain? _____

What other foot problems do you have / had?_____

OTHER CURRENT MEDICAL CARE: Please list current Health Care Providers, Diabetic Doctor and or Wound Care Doctor:

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

Last Physical: Date and Doctor's Name? _____

Last Chest X-ray _____ Last Blood Test _____ Last TB test _____ Last Tetanus_____

PAST MEDICAL SURVEY: ☐Bleeding problems ☐Healing Problems ☐Foot Infection ☐Peripheral Vascular Disease ☐Peripheral Neuropathy ☐History of DVT (Deep Venous Thrombosis) ☐History of PE (Pulmonary embolism) ☐Take Blood Thinners ☐Bleeding problems ☐Hemodialysis ☐Prosthetic Joint(s) ☐Heart Valve Replaced ☐Heart Attack ☐Irregular Heart Beat ☐Heart Murmurs ☐Congestive Heart Failure ☐Hypertension. ☐Stroke ☐AIDS /HIV ☐Hepatitis ☐Convulsions ☐Emphysema ☐Seizures ☐Cancer ☐Asthma ☐Rheumatoid Arthritis ☐Sickle-cell Disease ☐Blood Transfusions ☐Depression or anxiety. Explain history of any checked off issues:

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: PRINT CLEARLY the drug name, dosage and frequency of all medications including aspirin, birth control or vitamins. Alternatively: Pleases attach a Medication list that you have typed out to this Health History Questionnaire

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

OPIATES: Opiate pain medications BEING USED? ☐NO ☐YES – Drug and date last used opiate medications?_____

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DIABETIC ASSESSMENT: Do you have Diabetes Mellitus? ☐No ☐Yes Type: ☐1 ☐2 Last 7-day Average AM Glucose?_____
Date and Result of last Hg-A1C_____How is your Diabetes Controlled? _____
Are you on Dialysis: ☐No ☐Yes Type and Frequency: _____

WOUND ASSESSMENT: Do you have a wound? ☐Yes ☐No – SKIP TO SOCIAL HISTORY
How did the wound begin? _____
How long has the wound been present? _____Where is the wound(s) located? _____
What Doctor(s) have treated your wound(s) to date? _____
What Wound treatments have your received? ☐ Debridement ☐Wound Vacuum ☐Hyperbaric Oxygen ☐Skin Substitutes ☐Amputation ☐Other____
Dates these treatments occurred?_____
Describe your treatment progress? _____
_____
Describe any wound odor, drainage, bleeding or other signs? _____
Is the wound(s) painful? ☐No ☐Yes - Describe Pain:_____
Has the wound been infected? ☐No ☐Yes What was infected?_____
What antibiotics have been used? _____
Did an Infectious Disease Doctor Treat You? ☐No ☐Yes - Name of Doctor:_____
Date of last bacterial culture and sensitivity and findings _____
Have you had swelling and edema ☐No ☐Yes _____
Current Shoes and Insoles being used? _____
When do you replace your running or diabetic shoes shoe? _____
How are you off-loading the wound(s)? _____
How much water do you drink a day? _____
Do you follow Intermittent Fasting protocol? ☐No ☐Yes _____
Do you take supplements? ☐No ☐Yes Do you have any nutritional deficiencies? ☐No ☐Yes _____

SOCIAL HISTORY: Pregnancy: Are you pregnant? ☐No ☐Yes Birth control method? _____
Nicotine / Tobacco Use: ☐No ☐Yes - ☐Cigarettes. ☐Vape Packs per day _____ How many years?_____ Date Quit:_____
Alcohol: ☐No ☐Yes - How much each week?_____Recreation Drugs: ☐No ☐Yes _____
Living Situation: Where and who do you live with? _____
Do you have to go upstairs in your house or apartment building? ☐No ☐Yes _____
Emotional: Describe any emotional problems _____
Do you have any of the following? ☐Substance use disorder ☐Depression ☐Anxiety Disorders ☐Bipolar ☐Post-traumatic stress disorder
☐Schizophrenia ☐Personality disorders. ☐Attention deficit hyperactivity disorders ☐Other _____
Job Description / Work activities: _____
Exercise: Describe type and frequency_____
Fall and Balance History: How many times have your fallen?_____ When was your last fall?_____ Is your balance ☐Good ☐Poor

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: Where & when did you travel? _____

VACCINE HISTORY: ☐Measles ☐Pneumococcus ☐Typhoid ☐Yellow Fever ☐Polio ☐Cholera ☐Hepatitis A___B___

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

	Year Onset	Rare[R] Frequent[F]
CONSTITUTIONAL		
Weight Loss / Gain		
Weakness		
Fatigue		
Fever		
HEAD & NECK		
Headaches		
Neck Pain		
Fainting Spills		
EYES		
Glasses/ Contacts		
Blurred Vision		
Cataracts		
Glaucoma		
EAR, NOSE, THROAT & MOUTH		
Hearing Problems		
Loss of Balance		
Ringing in Ears		
Nose Bleeds		
Sleep Apnea		
Neck Artery Issues		
Dentures		
Gum Problems		
CARDIOVASCULAR		
Chest Pain		
Out of Breath a lot		
Sleep Sitting Up		
Night Leg Cramps		
Dizziness / Fainting		
Leg Blood Clots		
High Cholesterol		
High Blood Pressure.		
GENITOURINARY		
Dialysis		
Bladder Problems		
Painful Urination		
Dark/Bloody Urine		
Frequent Urination		
Prostate Trouble		

	Year Onset	Rare[R] Frequent[F]
SKIN I INTEGUMENT		
Rash / Condition		
Keloid Problems		
Bruise Easily		
Sores Hard to Heal		
Foot Fungus		
Toe Nail Problems		
Toe Nail Fungus		
Wound on feet		
Wound on leg		
Skin atrophy		
Loss of digital hair.		
Varicose veins		
GASTROINTESTINAL		
Stomach Nausea		
Vomiting		
Stomach Ulcer		
Constipation		
Diarrhea		
Abdominal Pain		
Appendicitis		
Appetite loss		
Excessive Thirst		
Black/Bloody Stool		
Gallbladder Trouble		
Colitis		
GYNECOLOGICAL		
Post-menopausal		
Breast Problems		
Menstrual issues		
RESPIRATORY		
Chronic Cough		
Coughing Up Blood		
Breath Shortness		
HEMATOLOGIC I LYMPHATIC		
Anticoagulants		
Daily Aspirin		
Jaundice Episodes		

	Year Onset	Rare[R] Frequent[F]
MUSCULOSKELETAL		
Foot Pain		
Foot Joint Pain		
Knee Pain		
Back Pain		
Muscle Weakness		
Scoliosis		
Unequal Leg Length		
Walking Leg Cramp		
Weak Ankles		
Swollen Ankles		
Gout in the Foot		
Flat Feet		
Exercise cramping		
Limited walking		
Cold leg and or foot		
NEUROLOGICAL		
Loss of Memory		
Neuropathy		
Foot Numbness.		
Poor Coordination		
Weakness		
Paralysis		
Muscle Weakness		
Muscle Spasms		
PSYCHIATRIC		
Nervousness		
Mood Swings		
Depression		
ENDOCRINE		
Cold Intolerance		
Severe Thirst		
Severe Hunger.		
Heavy Sweating		
Thyroid Trouble		
ALLERGIC I IMMUNOLOGIC		
Measles / Rubella		
Polio		
Mumps		
Scarlet Fever		
Mononucleosis		
Allergy Anaphylaxis		

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Diplomat, American Board of Foot & Ankle Surgery
Fellow, American Professional Wound Care Association
USC - UCSF Trained

FALL RISK, DEPRESSION AND ADVANCED DIRECTIVE

Patient: _____ DOB: _____ Date: _____

FALL RISK SELF-ASSESSMENT	Yes	No
Have you fallen in the past year? ☐0 ☐_____	☐	☐
Do you feel unsteady when standing or walking?	☐	☐
Do you worry about falling?	☐	☐
Do you feel you are a risk for falls?	☐	☐

DEPRESSION SCREENING

Question	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless?	☐	☐	☐	☐

Total Score: _____ If your score is 3 or greater, please consider making an appointment with your Primary Care Provider or a consultation with a Mental Health Provider with the understanding that depression is a treatable medical condition that can be reversed with counseling and or medications.

☐ I will discuss these findings with my primary care provider and or obtain a consultation with a mental health specialist.

☐ I understand the importance of maintaining a mental health and the need for intervention.

Patient Signature: _____ Date: _____

ADVANCE DIRECTIVE STATUS (FOR MEDICARE/MIPS REPORTING)

An advance directive is a document that tells healthcare providers what medical decisions you would want if you are unable to speak for yourself (for example: a Living Will and/or Durable Power of Attorney for Healthcare).

Please choose ONE:

A) ☐ **YES** — I have an advance directive already completed
☐ Living Will ☐ Healthcare Power of Attorney ☐ POLST ☐ Other: _____
☐ I am providing a copy today.
☐ I am not providing today, but is on file with whom _____

B) ☐ **NO** — I do NOT have an advance directive

C) ☐ **DECLINE** — I decline to answer / decline to discuss advance directives today.

Patient/Authorized Representative Signature: _____

Printed Name/Relationship (if representative): _____

Date: _____

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APPOINTMENT OF REPRESENTATIVE & AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Purpose: This form authorizes the practice below to act as the patient's appointed representative for claim disputes, appeals, grievances, and external review requests related to medical insurance company denials/requests.

(Intake Form — Read & Sign)

I, the undersigned patient/member ("Patient"), hereby appoint **OC Center for Wound Healing & Foot Care / Mark Reed, DPM** ("Representative") as my **authorized representative** for any and all matters related to my care with this practice, including but not limited to **prior authorizations, claims, denials, appeals, grievances, complaints, coverage determinations, redeterminations/reconsiderations, peer-to-peer communications, and external review processes** where applicable.

I authorize my health plan/insurer and any related entities (including medical groups/IPAs, utilization management vendors, third-party administrators, and review organizations) to **disclose, release, and transmit** to the Representative any and all **protected health information (PHI)** and plan/claim records reasonably necessary for these purposes, including medical records, clinical notes, imaging, labs, wound documentation/photos, case files, criteria/guidelines relied upon, denial rationales, reviewer notes, and all written determinations/notices. This authorization includes disclosure **by telephone, fax, mail, and electronic or web portal transmission** as permitted by law. This document is effective as of the date signed and remains valid for **three (3) years** from the date signed, unless earlier revoked by me in writing. **I understand I may revoke this authorization at any time** by providing written notice to the plan/insurer and/or the Representative; however, revocation will not affect actions taken in reliance on it before revocation is received. **A photocopy, scan, or electronic copy of this document shall be as valid as the original. Patient identifiers (including name, date of birth, and member/coverage information) are contained in the attached intake packet and are incorporated herein by reference.**

PATIENT SIGNATURE:

Patient/Member Signature: _____
Printed Name: _____
Date (MM/DD/YYYY): _____

REPRESENTATIVE/PROVIDER SIGNATURE:

Representative/Provider Signature: _____
Printed Name/Title: Mark Reed, DPM / OC Center for Wound Healing & Foot Care
Date (MM/DD/YYYY): _____

NOTICE OF PRIVACY PRACTICES
(This is a standard HIPPA Federal Form required for all patients)

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, a physician becomes involved in your care by providing assistance with your health care diagnosis or treatment.
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 under take 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 or admission may require that your relevant protected health information be disclosed to the health plan.
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 or 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.

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, or discovery request.

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.

_____	_____	_____
Printed Name of Patient, Parent, Gradian	Signature	Date

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