

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 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** _____

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: Please 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? _____

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? _____
 Enter the Date of Onset for the wound(s) _____ Where is the wound(s) located? _____
 What Doctor(s) have treated your wound(s) to date? _____
 What Wound treatments have you 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]		Year Onset	Rare[R] Frequent[F]		Year Onset	Rare[R] Frequent[F]
CONSTITUTIONAL			SKIN INTEGUMENT			MUSCULOSKELETAL		
Weight Loss / Gain	_____	_____	Rash / Condition	_____	_____	Foot Pain	_____	_____
Weakness	_____	_____	Keloid Problems	_____	_____	Foot Joint Pain	_____	_____
Fatigue	_____	_____	Bruise Easily	_____	_____	Knee Pain	_____	_____
Fever	_____	_____	Sores Hard to Heal	_____	_____	Back Pain	_____	_____
HEAD & NECK			Foot Fungus	_____	_____	Muscle Weakness	_____	_____
Headaches	_____	_____	Toe Nail Problems	_____	_____	Scoliosis	_____	_____
Neck Pain	_____	_____	Toe Nail Fungus	_____	_____	Unequal Leg Length	_____	_____
Fainting Spills	_____	_____	Wound on feet	_____	_____	Walking Leg Cramp	_____	_____
EYES			Wound on leg	_____	_____	Weak Ankles	_____	_____
Glasses/ Contacts	_____	_____	Skin atrophy	_____	_____	Swollen Ankles	_____	_____
Blurred Vision	_____	_____	Loss of digital hair.	_____	_____	Gout in the Foot	_____	_____
Cataracts	_____	_____	Varicose veins	_____	_____	Flat Feet	_____	_____
Glaucoma	_____	_____	GASTROINTESTINAL			Exercise cramping	_____	_____
EAR, NOSE, THROAT & MOUTH			Stomach Nausea	_____	_____	Limited walking	_____	_____
Hearing Problems	_____	_____	Vomiting	_____	_____	Cold leg and or foot	_____	_____
Loss of Balance	_____	_____	Stomach Ulcer	_____	_____	NEUROLOGICAL		
Ringing in Ears	_____	_____	Constipation	_____	_____	Loss of Memory	_____	_____
Nose Bleeds	_____	_____	Diarrhea	_____	_____	Neuropathy	_____	_____
Sleep Apnea	_____	_____	Abdominal Pain	_____	_____	Foot Numbness.	_____	_____
Neck Artery Issues	_____	_____	Appendicitis	_____	_____	Poor Coordination	_____	_____
Dentures	_____	_____	Appetite loss	_____	_____	Weakness	_____	_____
Gum Problems	_____	_____	Excessive Thirst	_____	_____	Paralysis	_____	_____
CARDIOVASCULAR			Black/Bloody Stool	_____	_____	Muscle Weakness	_____	_____
Chest Pain	_____	_____	Gallbladder Trouble	_____	_____	Muscle Spasms	_____	_____
Out of Breath a lot	_____	_____	Colitis	_____	_____	PSYCHIATRIC		
Sleep Sitting Up	_____	_____	GYNECOLOGICAL			Nervousness	_____	_____
Night Leg Cramps	_____	_____	Post-menopausal	_____	_____	Mood Swings	_____	_____
Dizziness / Fainting	_____	_____	Breast Problems	_____	_____	Depression	_____	_____
Leg Blood Clots	_____	_____	Menstrual issues	_____	_____	ENDOCRINE		
High Cholesterol	_____	_____	RESPIRATORY			Cold Intolerance	_____	_____
High Blood Pressure.	_____	_____	Chronic Cough	_____	_____	Severe Thirst	_____	_____
GENITOURINARY			Coughing Up Blood	_____	_____	Severe Hunger.	_____	_____
Dialysis	_____	_____	Breath Shortness	_____	_____	Heavy Sweating	_____	_____
Bladder Problems	_____	_____	HEMATOLOGIC LYMPHATIC			Thyroid Trouble	_____	_____
Painful Urination	_____	_____	Anticoagulants	_____	_____	ALLERGIC IMMUNOLOGIC		
Dark/Bloody Urine	_____	_____	Daily Aspirin	_____	_____	Measles / Rubella	_____	_____
Frequent Urination	_____	_____	Jaundice Episodes	_____	_____	Polio	_____	_____
Prostate Trouble	_____	_____				Mumps	_____	_____
						Scarlet Fever	_____	_____
						Mononucleosis	_____	_____
						Allergy Anaphylaxis	_____	_____



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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____



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



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 of others. We may disclose your protected health information to a government agency authorized to oversee the health care system

