San Luis Podiatry Group

PATIENT INFORMATION

First Name:	Middle Name:	Last Name:	
Social Sec.#:	Date of Birth:	Age:	Sex: M F
Home Address:			
City:	State:	Zip Code:	Email:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	
Race: (optional)	Ethnicity: (optional)	Marital Status: S M D W	Driver License #:
Occupation:	Employer:		
Is a patient in a skilled facility or enrolled in hospice? ☐ Yes ☐ No Name of facility or hospice:			
Primary Physician:	Referred by:		

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member/ Patient's ID:	Member/ Patient's ID:
Group #:	Group #
Insured's Name	Insured's Name
Insured's Employer	Insured's Employer
Employer's Contact #	Employer's Contact #

EMERGENCY CONTACT

Last Name:	First Name:
Relationship:	Phone: ( )

PREFFERED PHARMACY

Name of Pharmacy:	Phone ( )		
Address (or cross streets):	City:	State:	Zip Code:

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claim and to insure payment of services rendered on your behalf.

I request that payment of authorized insurance or Medicare benefits be made to me or on my behalf to Chris M. Byrne, DPM, for any services furnished by that provider. I authorize any holder of medical information about me to release to the insurance carrier or to Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

I understand that I am ultimately responsible for payments on my account. A $25.00 NSF check charge is applied to all accounts with a returned check. I understand that San Luis Podiatry Group has the right to request future services be paid in cash at the time of service and that unpaid balances over 120 days may be referred to an outside collection agency. In divorce/custody situations, the person with full time legal custody is responsible for the payment of our services. If 50/50 custody, we will bill the parent where the child resides for school purposes. If another parent has insurance responsibilities, we need that parent's legal authorization in writing, including legal signature, billing and insurance information.

If you have no insurance, payment is required at the time of service.

We understand that some appointments cannot be kept due to unforeseen circumstances. However, we ask for a 24-hour notice so that we can offer other patients a chance to be seen.

If for any reason you are more than 15 minutes late, we may have to reschedule your appointment.

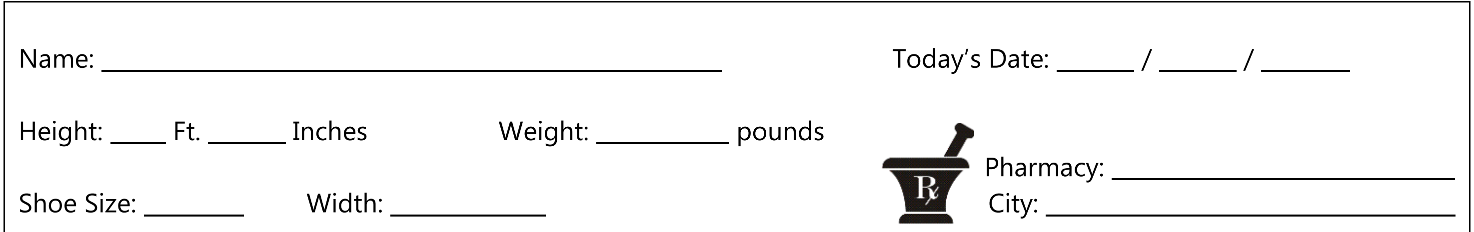
I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH BY THE SAN LUIS PODIATRY GROUP.

Signature	Date

San Luis Podiatry Group

Chris M. Byrne, DPM, FACFAS	***Brandon Slade, DPM***	***Julie M. Chatigny, DPM***	***Stephen Burke, CPed***
Podiatric Surgeon	Podiatric Surgeon	Podiatric Surgeon	Certified Pedorthist

Please circle the Specialist you are seeing today



Name: ______________________________ Today's Date: ______ / ______ / _______

Height: _____ Ft. ______ Inches Weight: __________ pounds

Pharmacy: ________________________

Shoe Size: ________ Width: ____________ City: ____________________________

Briefly describe complaint today:

____

____

____

Check all that apply:

	TOE	**FOOT**	**ANKLE**	**LEG**
RIGHT	◯	◯	◯	◯
LEFT	◯	◯	◯	◯
BOTH	◯	◯	◯	◯

Date of injury / Onset of symptoms: ____

Type of pain / discomfort? *(check all that apply)*

◯ Dull Ache	◯ Deep Ache	◯ Stabbing	◯ Burning	◯ Tingling
◯ Numbness	◯ Electrical	◯ Cold	◯ Swelling	◯ Wound

When? *(check all that apply)*

◯ Constant	◯ Only in AM	◯ Only in PM	◯ Only at Bedtime	◯ After exercise
◯ During Exercise	◯ Walking	◯ Standing	◯ Running	◯ Sitting

What have you tried to help with symptoms? *(check all that apply)*

O Ice	O Elevation	O Crutches	O Physical Therapy	O New shoes
O Heat	O Stop exercising	O Non-weight-bearing	O Shoe inserts (brand) ____________________	

What makes it better: ____

What makes it worse: ____

Do you wear orthotics? ◯ Yes ◯ No

Over-the-counter brand: ______________________________

Custom: ***how old are they ?*** ______________________________

List of Current Medications:		
1.	**2.**	**3.**
4.	**5.**	**6.**

Do you exercise?
◯ Yes ◯ No

How many times per week? ____________

What kind of exercise? ____

San Luis Podiatry Group

Name: ____ Today's Date: ______ / ______ / _______

Allergies: *(check all that apply)*						
	1.	Reaction:	○ Rash	○ Hives	○ Anaphylaxis	○ Breathing issues
	2.	Reaction	○ Rash	○ Hives	○ Anaphylaxis	○ Breathing issues
	3.	Reaction	○ Rash	○ Hives	○ Anaphylaxis	○ Breathing issues

Medication Intolerance *(check all that apply)*					
	1.	Reaction:	○ Nausea	○ Vomiting	○ Headache
	2.	Reaction	○ Nausea	○ Vomiting	○ Headache
	3.	Reaction	○ Nausea	○ Vomiting	○ Headache

Smoking *(check all that apply)*

Do you currently use?	○ Yes	○ No	○ eCigarettes	○ Tobacco cigarettes	○ Marijuana
Have you ever used?	○ Yes	○ No	○ Cigars	○ Vapor cigarettes	
Stop Date	____/____/_____		Pack(s) per day _________		# of yrs _________

Chewing tobacco

Do you currently use? ○ Yes ○ No How much per day? _______________

Are you interested in quitting tobacco use? ○ Yes ○ No

Alcohol *(check all that apply)*

Do you currently use?	○ Yes	○ No	○ Beer	○ Spirits (gin, whiskey, tequila, scotch, bourbon, vodka, etc.)
Have you ever used?	○ Yes	○ No	○ Wine	# of oz per week ______________________________
Stop Date	____/____/_____		# of yrs	__________________

Illicit Drugs *(check all that apply)* ***This is held within strict confidence between you and your physician***

Do you currently use?	○ Yes	○ No	○ Methamphetamine	○ LSD	○ Bath Salts
Have you ever used?	○ Yes	○ No	○ Cocaine	○ Heroin	○ Salvia

Surgical History / Hospitalizations:

Date: __________ / __________ Procedure / Reason: ____

Date: __________ / __________ Procedure / Reason: ____

Date: __________ / __________ Procedure / Reason: ____

Date: __________ / __________ Procedure / Reason: ____

Family History: *(check all that apply)*

Heart problems	○ Father	○ Mother	○ Brother	○ Sister	○ Child
High blood pressure	○ Father	○ Mother	○ Brother	○ Sister	○ Child
Diabetes	○ Father	○ Mother	○ Brother	○ Sister	○ Child
Cancer	○ Father	○ Mother	○ Brother	○ Sister	○ Child
Stroke	○ Father	○ Mother	○ Brother	○ Sister	○ Child

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Name: ____ Today's Date: ______ / ______ / ______

Medical History: *(check all that apply)*

HEART
- ○ Abnormal heart beat / Atrial fibrillation
- ○ Congestive heart failure
- ○ Heart Attack
- ○ Angina
- ○ Heart murmur
- ○ Pacemaker
- ○ Implanted defibrillator
- ○ Sick Sinus Syndrome

VASCULAR
- ○ Leg cramping
- ○ Claudication (legs tire after walking short distance)
- ○ Hypertension / High blood pressure
- ○ Blood clotting disorder / DVT or PE
- ○ High Cholesterol / High Triglycerides

LUNGS
- ○ Asthma
- ○ Emphysema
- ○ COPD (Chronic Obstructive Pulmonary Disease)
- ○ Cough
- ○ Tuberculosis

HEMATOLOGIC
- ○ Unusual bleeding
- ○ Easy bruising
- ○ HIV / AIDS
- ○ Anemia
- ○ Cancer

ENDOCRINOLOGY
- ○ Thyroid disorder
- ○ Diabetes mellitus Type I
- ○ Diabetes mellitus Type II
- ○ Diabetes insipidus
- ○ Thyroid disorder

GENITOURINARY
- ○ Kidney disease
- ○ On dialysis
- ○ Bladder incontinence
- ○ Bladder infection
- ○ Sexually transmitted infection(s)
- ○ Prostate issues
- ○ Pregnant

GASTROINTESTINAL
- ○ Blood in stool
- ○ Jaundice
- ○ Cirrhosis of the liver
- ○ GI ulcers
- ○ GI bleeding
- ○ Hepatitis *(List Type)*

DERMATOLOGICAL
- ○ Rashes / hives
- ○ Open sores / wounds
- ○ Psoriasis
- ○ Porphyria
- ○ Itching
- ○ Dry skin
- ○ Blisters
- ○ Odor

PSYCHIATRIC
- ○ Anxiety
- ○ Depression
- ○ Bipolar disorder
- ○ Schizophrenia
- ○ Suicidal thoughts
- ○ Obsessive compulsive disorder
- ○ ADD / ADHD

MUSCULOSKELETAL
- ○ Joint pain / swelling
- ○ Osteoarthritis
- ○ Back pain
- ○ Neck pain
- ○ Muscle aches
- ○ Muscle tenderness
- ○ Gout
- ○ Limited range of motions

RHEUMATOLOGICAL
- ○ SLE / Lupus
- ○ Rheumatoid arthritis
- ○ Juvenile rheumatoid arthritis
- ○ Sjogren's syndrome
- ○ Anklyosing spondylitis
- ○ Psoriatic arthritis
- ○ Behcet's disease
- ○ Vasculitis
- ○ Scleroderma / CREST syndrome
- ○ Reactive arthritis
- ○ Other: ***(List type)***

NEUROLOGICAL
- ○ Paralysis
- ○ Seizures
- ○ Stroke / TIA
- ○ Numbness
- ○ Loss of balance
- ○ Dizziness
- ○ Migraines
- ○ Confusion
- ○ Alzheimer's dementia
- ○ Other dementia
- ○ Huntington's disease
- ○ Parkinson's disease
- ○ Multiple sclerosis ***(List type)***
- ○ Cognitive deficit

ADDITIONAL PERTINENT INFORMATION:

San Luis Podiatry Group

Name: ____ Today's Date: ______ / ______ / ______

Video & Photography Disclaimer:

I hereby give my consent to San Luis Podiatry Group to photograph, film, videotape and then use, reproduce, and publish said images of me and/or my child/children.

____ ____

Please print name *Please print child's name*

I agree that photographs/negatives, film, or videotapes thereof shall constitute the sole property of San Luis Podiatry Group with full right of disposition for educational purposes, including the right to publish on affiliated websites.
I hereby release San Luis Podiatry Group and his/her legal representatives and assigns from any and all claims whatsoever in connection with the use, reproduction, publication of the images thereof.

____ ______ / ______ / ______

Signature of parent or guardian *Date*

____

Signature for minor child

Acknowledgment Receipt

I am aware of the privacy standards of San Luis Podiatry Group and my rights and responsibilities as a patient under the Healthcare Portability and Accountability Act of 1996 (HIPAA) and other governmental regulations. Should I request additional information, it will be provided by San Luis Podiatry Group staff. Otherwise, all exchanges of information including prescription history, medical history, and conversations about my condition will be in accordance with stipulated policies and procedures.

○ **I authorize** the practice to release any or all information concerning my medical care to the individual listed as my **emergency contact.**

○ **I authorize** the practice to release any or all information concerning my medical care to the individual named as my **spouse/parent/guardian.**

○ **I authorize** the practice to release any or all information concerning my medical care to the individual(s) **listed below:**

1. ____ ____

 Please print name *Relationship to patient*

 ________ / ________ / ________ ( ) __________ - ____________________

 Date of birth *Phone number*

2. ____ ____

 Please print name *Relationship to patient*

 ________ / ________ / ________ ( ) __________ - ____________________

 Date of birth *Phone number*

____

Please print patient's name

____ ________ / ________ / ________

Patient's signature ***Date***