1551 Bishop St., Ste. 310C
San Luis Obispo, CA 93401
805-543-7788

San Luis Podiatry Group

1101 Las Tablas Rd., Ste. L
Templeton, CA 93465
805-434-2009

customerservice@sanluispodiatrygroup.com

First Name:	Middle Name:	Last Name:	
Social Sec.#:	Date of Birth:	Age:	Sex: M F
Mailing Address:			
City:	State:	Zip Code:	Email:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	
Race: (optional)	Ethnicity: (optional)	Marital Status: S M D W	
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: ( )

PREFERRED PHARMACY

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

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 of Patient or Parent/Guardian	Date

San Luis Podiatry Group

Anthony Martin, DPM **Chris Byrne, DPM** **Yusuke (Kevin) Kihira, DPM**

Name: _____ Today's Date: _____ / _____ / _____

Height: _____ Ft. _____ Inches Weight: _____ pounds

Shoe Size: _____ Width: _____

Pharmacy: _____

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)*

☐ Ice ☐ Heat ☐ Elevation ☐ Stop exercising ☐ Crutches ☐ Non-weight-bearing ☐ Physical Therapy ☐ New shoes ☐ 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?	How many times per week?	What kind of exercise?
◯ Yes ◯ No	_____	_____

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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
- ☐ Other

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

Agreement & Privacy

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, and conversations about my condition will be in accordance with stipulated policies and procedures. history, medical Having accurate information about your medications is critical to treating your symptoms/ illness properly and for avoiding potentially dangerous drug interactions. By signing below, you are authorizing this practice to obtain and review your medication fill history from your pharmacy/ pharmacies

☐ **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 asmy **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***

San Luis Podiatry Group

Financial Policy

Insurance

We are contracted providers for most major insurance plans, but that does not mean your insurance will pay for the services provided. On your behalf, we will bill your insurance company to determine insurance vs. patient responsibility. Please provide us with accurate billing information including your up to date insurance card(s). If your visit requires prior authorization, please provide all necessary authorization paperwork prior to your visit.

If you are uninsured, we will do our best to keep your healthcare costs to a minimum by charginggenerally accepted insurance reimbursement rates. Your physician will help direct your care and discuss any costs associated with the healthcare recommendations at the time of treatment. Full payment is due at time of service.

Payments

All co-payments, unmet deductibles, and account balances are due at the time of the visit in the form of cash, checks, Visa or MasterCard. There will be a charge of $25.00 for returned checks. Accounts that are delinquent will be turned over to collection at the discretion of our billing office. If you would like to make payments on an existing bill, please call our office and ask to speak to our billing department. **Minors** must be accompanied by their parent or legal guardian and that adult is responsible for payment in full at the time of service.

Supplies

Some office supplies that your podiatric physician may recommend and provide may not be covered under your insurance plans. We are unable to bill your insurance for many of these items and you will be charged at the time of your visit. We are happy to provide receipts for any items that are purchased at our office.

Fees

Due to rising expenses, we have instituted the following charges. These charges are not covered by insurance and are the full responsibility of the patient.

Missed appointments without 24-hour notice

Missed Office Visit (or more than 15 min late to appointment)	$25.00
Cancelled or Rescheduled Office Visit (without 24 hr. notice)	$25.00

Forms Fees

Disability	$25.00
FMLA	$25.00
Typed letters for any reason	$25.00
Workers Compensation paperwork	$25.00
Medical records (depending on the size)	$20.00 and up
Copies of tests/images	$25.00

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Signature _____ Date _____