Redlands Podiatry Group PC
16 E. Fern Ave Suite A
Redlands, CA 92373
909-792-6066 office, 909-792-4424 fax

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ____/_____/_____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ____/____/____ AGE: ____ SEX: M F
LAST FIRST MI

SOCIAL SECURITY NUMBER:_____

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_____) _____-_____ YES NO

WORK PHONE #: (_____) _____-_____ YES NO

CELL PHONE #: (_____) _____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

RACE:_____ ETHNICITY:_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (_____) _____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (_____) _____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____
PHARMACY: _____ LOCATION: _____ PHONE #: (_____) _____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) _____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____

WHO REFERRED YOU TO US?_____

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

YOUR MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:											

HAVE YOU EVER HAD A FOOT ULCER Y N
TOE OR FOOT AMPUTATION Y N
LOWER EXTREMITY ARTERIAL BYPASS OR STENT Y N

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____		_____	
_____		_____	
_____		_____	

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐CHILDREN–AGE(S) _____ ☐PET(S)–WHAT KIND? _____
☐ELDERLY OR DISABLED FAMILY MEMBER ☐OTHER _____

EXERCISE: ☐ NEVER ☐RARE ☐ OCCASIONAL ☐WEEKLY ☐SEVERAL TIMES A WEEK ☐DAILY

TYPES OF EXERCISE: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐TAPE ☐ LATEX ☐SHELLFISH ☐ IODINE ☐OTHER _____
☐NONE KNOWN

HEIGHT_____
WEIGHT_____
SHOE SIZE_____

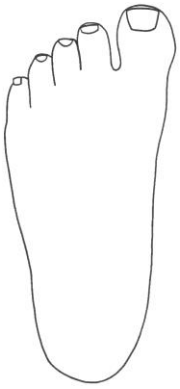
PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

CURRENT PROBLEM

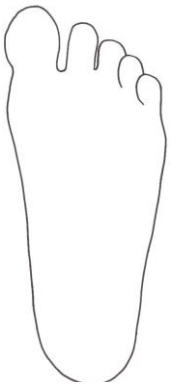
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

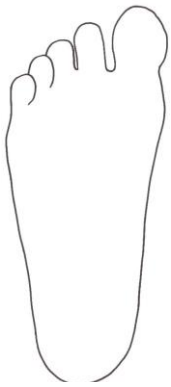


BOTTOM OF FOOT

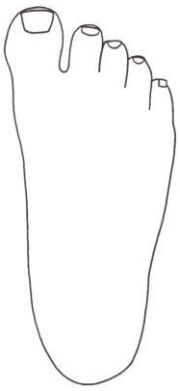
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

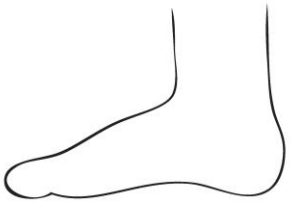


BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____
SIGNATURE

_____
DATE

Patient Consent Form
All Patients: PLEASE READ AND SIGN AT #1, #2, & #3 PRIOR TO FIRST VISIT
1) CONSENT FOR TREATMENT
I,_____ **(please print name)** am voluntarily seeking medical care and treatment from the doctors at Redlands Podiatry Group PC, give permission to the medical Redlands Podiatry Group PC to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations and recommendations they provide me.
_____ ___/___/___
Patient/Guardian Signature Date
_____ _____
Translator's Name, if applicable Translator's Signature, if applicable

2) CONSENT TO BILL

· If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will
plan to pay or be billed for any outstanding balances in accordance with Redlands Podiatry Group PC billing policy;

· If my insurance is accepted, I authorize payment of benefits to Redlands Podiatry Group PC or will reimburse Redlands Podiatry Group PC if I am paid directly by my carrier;

· I hereby authorize that Redlands Podiatry Group PC may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy;

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

· I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory;

· I understand that my insurance may not cover all charges deemed medically necessary by Redlands Podiatry Group PC;

· I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

_____ ___/___/___
Patient/Guardian Signature Date

_____ _____
Translator's Name, if applicable Translator's Signature, if applicable

3) CONSENT TO PHOTOGRAPH

Here at Redlands Podiatry Group PC we will sometimes take pictures to assist in documentation of your case. We will do our best to limit these pictures solely to your feet. These pictures will be part of your medical record and will not be shared except with referring doctors or insurance companies that need this information or those you designate through a release of information for us to send these records to.

· I consent to being photographed as described above to assist in maintenance of my medical record.

_____ ___/___/___
Patient/Guardian Signature Date

_____ _____
Translator's Name, if applicable Translator's Signature, if applicable

4) NOTICE OF NO-SHOW POLICY

In an effort to improve quality of care to patients and decrease wait times the Redlands Podiatry Group PC has adopted the following no show policy.

A failure to notify the office of cancelation with 24 hours of your appointment will be considered a no show. Failing to show up to an appointment or cancel an appointment 24 hours prior to the appointment may result in being billed 25 dollars per appointment and, this will not be covered by your insurance company and must be paid prior to being seen again. After failing to show up for an appointment 3 times in a 12-month period you may be dismissed from the practice. We appreciate your help in this matter as failure to cancel appointments makes it more difficult for other patients to be seen resulting in longer wait times and if you have any questions regarding this problem please feel free to contact us and we will be happy to discuss our policy with you and any special needs that you may have.

I have read and understand the No-Show policy

_____ ___/___/___
Patient/Guardian Signature Date

_____ _____
Translator's Name, if applicable Translator's Signature, if applicable

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

ACKNOWLEDGMENT OF RECIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices or HIPPA information and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized representative (if applicable)

_____

Signature