Total Foot & Ankle Restoration & Preservation

Patient Information

28078 Baxter Rd Ste 424 Murrieta, CA 92563
Tel: (951)-679-1020 Fax: (951)-679-5844

Please fill out completely or mark areas "n/a" if they do not apply.

Name (Last, First, M.I.)____

Sex: □M □F Date of Birth ______/______/_________ Age _______Social Security # _______/_______/_________

Marital Status: □Single □Married □Widowed □Divorced

Race: ______________________ Ethnicity: □Hispanic/Latino □Not Hispanic/Latino Preferred Language: ______________________

Address______________________________________City______________________________State______Zip_______

Home Phone______________________________Work____________________________Cell/Pager ______________________

EMAIL ADDRESS: ________________________________

Employer_____________________________________City___________________________State_______Zip___________ Retired

In case of emergency, notify___________________________Phone______________________Relation to Patient_______________

Address______________________________________City___________________________State_______Zip__________

Primary Care Physician's Name____ Phone: ______________________

Known Drug Allergies: ____

Pharmacy Name/Number___________________________________

Insurance Information

Primary Insurance Company____Phone______________________________

Insured's Name_________________________________DOB_____/_____/_________Relation to Patient____________________

ID Number ____Group Number______________________________________

Employer Name____

Secondary Insurance Company____Phone______________________________

Insured's Name_________________________________DOB_____/_____/_________Relation to Patient____________________

ID Number ____Group Number______________________________________

Employer Name____

I give my consent for TFAR&P, A Professional Corporation employees or associates to leave messages on my answering machine or voicemail regarding my medical care, test results, appointment confirmation, and payment issue.

____
Signature of Patient, Parent, or Guardian

I certify that the above insurance information is current and accurate; I authorize assignment of insurance benefits to TFAR&P.. I understand that I am financially responsible for all charges whether or not paid by insurance, for myself or my dependents. I authorize the use of my signature on all insurance submissions. TFAR&P. and its representatives may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I agree to pay all costs of collection action including legal fees and collection fees up to 33 1/3% if I fail to pay my bill. Medical records will not be released without proper signed authorization.
I have been given the opportunity to review the HIPAA Disclosure Policy regarding my Protected Health Information and understand the manner in which this office uses my information. I agree with the exception of: ____.

____
Signature of Patient, Parent, or Guardian Date

____ ____
Please print name of Patient, Parent or Guardian Relationship to Patient

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed:

(EXAMPLE: HYPERTENSION, DIABETES, ETC)

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Are you currently on Home Health Services (example Home Health Nurse) ☐ YES ☐ NO

Have you ever had a blood transfusion? ☐ YES ☐ NO

Have you ever had antibiotic infusion? ☐ YES ☐ NO

List your medications and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

ALLERGIES to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to “binge” drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

FAMILY HISTORY

LIST AGES AND HEALTH STATUS OF PARENTS, IF DECEASED INCLUDE CAUSE OF DEATH AND AGE AT TIME OF DEATH.

MOTHER____

FATHER____

SYSTEMIC REVIEW
CIRCLE ALL THAT APPLY:

SKIN: SKIN DISEASE ITCHING HIVES ABNORMAL PIGMENT

HEAD: HEADACHES FAINTING CONVULSIONS LOSS OF VISION GLAUCOMA CATARACTS DEAFNESS RINGING OF EARS NOSEBLEEDS SINUS TROUBLE DENTURES HOARSENESS DIFFICULTY SWALLOWING

SORE THROAT

NECK: STIFFNESS THYROID TROUBLE ENLARGED GLANDS

CHEST: DIFFICULTY BREATHING ASTHMA BRONCHITIS

CARDIOVASCULAR: CHEST PAIN DIFFICULTY WALKING HEART ATTACKS SWELLING OF HANDS AND FEET HEART MURMUR HIGH BLOOD PRESSURE STROKE IRREGULAR HEARTBEAT

GASTROINTESTINAL: NAUSEA DIARRHEA ULCERS BLOODY VOMIT BLOODY STOOL

GALLBLADDER DISEASE HEPATITIS

GENITOURINARY: PAINFUL URINATION BLOODY URINE KIDNEY STONES

OB/GYN: PREGNANCIES DELIVERIES

NERVOUS SYSTEM: CONVULSIONS FAINTING PARALYSIS ATROPHY SPASTICITY

TREMORS NUMBNESS STRANGE SENSATIONS PSYCHOSIS

MUSCULOSKELETAL: ARTHRITIS WEAKNESS ARTIFICIAL JOINTS JOINT STIFFNESS OR SWELLING

CRAMPING

HEMATOLOGICAL: BLEEDING BRUISING ANEMIA PHLEBITIS

GENERAL: RECENT WEIGHT CHANGES

HAVE YOU BEEN IN GOOD GENERAL HEALTH MOST OF YOUR LIFE? YES NO

Total Foot & Ankle Restoration & Preservation

CONSENT TO TREATMENT

I/We do hereby consent to and authorize the performance of all medical treatment(s) service by TFAR&P, which they deem advisable. I fully understand that the agreement and consent will continue until cancelled by me in writing.

_____________AUTHORIZATION IS HEREBY GIVEN TO TFAR&P TO RENDER NECESSARY MEDICAL
Please Initial TREATMENT TO ANY MINOR OF WHICH I AM **THE PARENT OR LEGAL GUARDIAN.**

_____________I authorize TFAR&P appointment schedulers to leave messages on my answering machine regarding
Please Initial date and time of medical appointment(s).

Patient/Guardian Signature:____ Date____________________

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

The undersigned assigns any health care benefits of any type whatsoever arising out of any policy or policies of insurance insuring the patient or any other party liable to the patient, to be paid directly to **TFAR&P** for application on my bill. The undersigned hereby further assigns all rights and interests in any claim, demand, or cause of action which the patient may now or may in the further have against any said insurance company for collection of any amount payable under any policy of insurance of for any reason of failure to pay any amount payable under any policy of insurance. The undersigned agrees whether signing as agent or as patient that she/he is individually obligated to pay any amounts owed in full for services rendered in accordance with the regular rates and terms.

The undersigned understands that in the event the patient's account becomes delinquent, **TFAR&P** reserves the right to terminate the provision of services upon advance notice to the patient's agent.

Should the patient's account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collections expense. All delinquent accounts bare interest at the legal rate.

MEDICARE CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given to **TFAR&P** in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release of my medical information for Medicare claim to the Medicare Program or its agents. I request that payment of authorized benefits be made to **TFAR&P**

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **TFAR&P**. to furnish my medical records (including medical history, mental or physical condition, services rendered or treatment received) for the purposes of review, investigation, evaluation of any application, the processing of any claim, quality assurance activities, utilization review, financial audit, continuing my medical care, or any other purpose reasonably related to these activities. I also grant **TFAR&P**. the right to provide access to my medical records for purpose of review by any government regulatory agency of other accrediting organization

I understand that any medical information disclosed under this authorization may not be further used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I further understand that I have a right to receive a copy of this authorization upon my request.

Patient's Signature:____Date____________________

Print Name:____

Total Foot & Ankle Restoration & Preservation

Medical Photography Consent Form

Patient Consent:

I________________________________, consent to medical images being made of me or my child/dependent. I agree that duplicates may be made for the referring doctor.

I agree that the images may be placed in my medical record for patient identification, future treatment or electronically emailed to my treating health professional.

By signing below, I confirm that I understand this consent form.

____

Signature of Patient/Parent or Guardian Date

____

Total Foot & Ankle Restoration & Preservation Staff Date

Total Foot & Ankle Restoration & Preservation

PERSONAL INFORMATION CONSENT

I, ____________________________________, give the Physician and staff of **Total Foot & Ankle Restoration & Preservation**

Please Print Patients Name

Permission to discuss my medical condition(s) with the following contacts:

Please be advised that you are allowing our office to discuss your personal information with the contacts listed below. If there is any specific information that you would not like discussed, please list:

____
____
____
____
____

CONTACTS WE ARE *ALLOWED* TO DISCUSS INFORMATION WITH:

Name____Phone___________________________

Relationship____

Name____Phone___________________________

Relationship____

Name____Phone___________________________

Relationship____

THIS IS ANY INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED

Patient's Signature____**Date**__________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

____

____

____

______________________________ ____________________
Employee signature *Date*

TOTAL FOOT AND ANKLE OFFICE POLICIES

DBA: MED-PED ID

APPOINTMENTS: Our hours are by appointment only.

- **IF YOU ARE MORE THAN 15MINUTES OR MORE TO YOUR APPOINTMENT, YOU WILL BE RESCHEDULED.**
- **NEW PATIENTS MUST BE IN OFFICE 15 MINUTES PRIOR TO APPOINTMENT TIME TO REGISTER.**
- **PLEASE CALL 24 HOURS IN ADVANCE WHEN CANCELING AN APPOINTMENT.**
- **MISSED APPOINTMENT WILL BE BILLED $35.**

MESSAGES:

- All messages received will be returned within 12-24 hours.

CO PAYS/PAYMENTS: Co-pays and/or payment are due at the time of service. Service includes in person or telemedicine. For your convenience we accept cash, checks, or credit cards (Visa, Mastercard, Discover & Amex)

PRESCRIPTIONS: ALLOW 2 BUSINESS DAYS FOR ALL REFILLS

- You must call your pharmacy to refill (May take up to 3-5 days to process prescription refill requests.)
- *DO NOT* call the office for the refill, this will only delay your refill (Some exceptions apply to specialty medications).
- *DO NOT* wait until you run out of your meds. **Call the pharmacy 2 weeks prior to last dose.**

MEDICAL RECORDS/FORMS:

- There is a $0.25 cent per page fee up to $15 max.
- Allow 72hour turnaround time. You will be called to pick up records when ready.
- Personal forms, please allow 3 days for pick up.

MED-PED ID HAS A ZERO TOLERANCE POLICY AGAINST AGGRESSIVE BEHAVIOR, UNREASONABLE EXPECTATION, BULLLYING, PROFANITY, AND VERBAL ABUSE TOWARDS OUR STAFF FROM PATIENTS/GUARDIAN/FAMILY MEMBER. ANY DISPLAY OF THIS BEHAVIOR WILL BE SUBJECT TO BEING TERMINATED AS A PATIENT FROM OUR PRACTICE.

AS OUR OFFICE CONTINUES TO GROW, WE MUST ENFORCE POLICIES THAT WILL BENEFIT OUR PATIENTS AS WELL AS TO HELP MED-PED ID RUN A MORE EFFIENT PRACTICE.

Thank you for understanding.

Patient Signature:______________________________________Date:_______________

Witness:____Date:_______________