Foothill Podiatry
123 Margaret Lane Ste A1
Grass Valley, CA 95945
Telephone: (530) 477-7200

Please take a moment to review, making sure all fields are accurate and complete.
Thank you!

Patient Name: _____

Mailing Address: _____

City/State/Zip: _____

Home Phone:_____ **Ok to Leave Message?** Yes No Brief Extended

Work Phone: _____ **Ok to Leave Message?** Yes No Brief Extended

Cell Phone: _____ **Ok to Leave Message?** Yes No Brief Extended

Date of Birth: _____ **Social Security Number:** _____
Marital Status: _____ **Email Address:** _____

Primary Care Doctor: _____ **Referring Physician:** _____

Insurance Information
Primary Insurance: _____ **Subscriber Name:** _____
Secondary Insurance:_____ **Subscriber Name:** _____

Employer Information
Employer Name: _____ **Phone Number:** _____

Additional Information
Pharmacy Name: _____

Race: *(circle one)* American Indian or Alaskan Native Asian Native Hawaiian Black or African American White Hispanic Other

Ethnicity: *(circle one)* Hispanic Non-Hispanic

Language: *(circle one)* English Spanish Indian Russian Other

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I understand this office is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This is to keep my protected health information (PHI) private. I understand that the office HIPPA policy is available to me upon request. My signature below authorizes the release of any medical information necessary to process claims and request that payment of all assigned benefits be made to the provider of services. I understand that I am financially responsible for non-covered benefits, deductibles, and co-payments at the time of service. I have read and understand the financial policy. Should the account be referred to a collection agent, the undersigned shall pay all collection expenses.

Signed: _____ **Date:** _____
Insured or Authorized Person

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

What foot problem brought you to our office? _____

_____

Did your family doctor request you be seen in our office? _____

Have you seen a podiatrist before? If so, who and why? _____

_____

MEDICAL HISTORY

Which of your immediate relatives have had any of the following diseases:

Cancer _____ Diabetes _____

Heart Trouble _____ High Blood Pressure _____

Kidney Disease _____ Mental/Emotional Disease _____

Stroke _____ Arthritis _____

Please indicate if you have had any of the following problems:

Nature of problem	circle		Date	Nature of problem	circle		Date
Recent Weight Loss	Y	N		Headaches	Y	N	
Vision trouble	Y	N		Hearing trouble	Y	N	
Allergies/Hay fever	Y	N		Asthma	Y	N	
Thyroid	Y	N		Diabetes	Y	N	
Skin	Y	N		Anemia	Y	N	
Heart	Y	N		Mitral Valve Prolapse	Y	N	
Circulatory	Y	N		High Blood Pressure	Y	N	
Respiratory	Y	N		Shortness of Breath	Y	N	
Liver Disease	Y	N		Gall Bladder Disease	Y	N	
Stomach trouble	Y	N		Swelling: feet/ankle	Y	N	
Arthritis	Y	N		Kidney trouble	Y	N	
Gout	Y	N		Bleeding tendency	Y	N	
Scarring tendency	Y	N		Joint pain/stiffness	Y	N	
Numbness: feet/ankle	Y	N		Cramps in feet/legs	Y	N	
Low back pain	Y	N		Psychiatric ailment	Y	N	
Fainting/convulsions	Y	N		Stroke	Y	N	
Other problems	Y	N					

Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____

Do you take illegal drugs? _____ How much? _____

Have you had any physical therapy? _____ When? Where? Why? _____

_____

Please give details of any operations or serious injuries: _____

_____

Are you pregnant? _____ If so, how many months? _____

Please list all medications you are currently taking: _____

_____

Are you allergic to any medications? _____

_____ _____

Patient Signature Date

FINANCIAL POLICY

Thank you for choosing Foothill Podiatry Clinic (FPC) as your podiatric care provider. We are committed to your treatment being successful.

INSURANCE: For the convenience of our patients, Foothill Podiatry Clinic is contracted with the following insurance plans: Sierra Nevada Medical Associates – Blue Shield HMO, Blue Cross HMO, Health Net HMO, United Healthcare HMO, Secure Horizons HMO; Blue Shield PPO, Blue Cross PPO, PHCS, Champ VA/Tricare, Cigna, United Healthcare PPO, and Medicare.

MEDICARE: FPC participates with Medicare. You are responsible for paying your 20% co-insurance and any amounts applied to your annual deductible.

MEDICARE SUPPLEMENTAL PLANS: FPC will submit a claim to your supplemental insurer on your behalf. You will be responsible for any balance left over as a result of your insurance policy's co-payments or deductibles.

HMO plans: All HMO plans require a referral and/or pre-authorization from your primary care physician before you are seen in our office.

MEDI-CAL PROGRAMS/CA H&W: All plans require a referral and/or pre-authorization from your primary care physician before you are seen in our office. If this is not obtained, you will be responsible for full payment at the time of service.

NON-CONTRACTED INSURANCE: FPC will courtesy bill your insurance if it is not on our contracted list. However, you will be responsible for full payment at the time of service, as your insurance company will send payment directly to you as reimbursement.

SELF PAY/ CASH: If you do not have insurance you are required to pay the full amount due at the time of service. A 20% cash pay discount will be given.

MISSED APPOINTMENTS: FPC reserves the right to charge you **$50.00 fee** if you have missed an appointment or failed to cancel your appointment more than 24 hours in advanced. **This fee will need to be collected prior to making another appointment.**

PAYMENTS: We accept Personal checks, Cash, VISA, MasterCard, Discover, and money orders.

BAD CHECKS: FPC has a bad check fee of **$25.00** payable in cash or cashier check in addition to the face value of the bad check. FPC prosecutes offenders to the maximum extent of the law.

IMPORTANT!!! You are the beneficiary of your particular insurance plan and are bound by that contract with your insurance company. If that company deems you ineligible for benefits, or denies coverage of a procedure or service as a non-covered benefit, you are responsible for payment. If your insurance coverage changes please provide us with the new information as soon as possible.

Signature: _____ **Date:** _____

Update 3/17/2016

DUE TO NEW PRIVACY ACTS, WE ARE UNABLE TO LEAVE INFORMATION WITH ANYONE OTHER THAN YOU UNLESS WE GET YOUR PERMISSION TO DO SO. PLEASE COMPLETE THE INFORMATION BELOW –

THANK YOU!

YOUR NAME _____ DATE _____

DO WE HAVE PERMISSION TO LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME? _____ YES _____ NO

DO WE HAVE PERMISSION TO LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? _____ YES _____ NO

IF YES ON VOICE MAIL? _____ WITH RECEPTIONIST? _____

DO WE HAVE PERMISSION TO DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD? _____ YES _____ NO

IF YES, WHOM _____

RELATIONSHIP TO YOU: _____

IF YES, WHOM _____

RELATIONSHIP TO YOU: _____

IF YES, WHOM _____

RELATIONSHIP TO YOU: _____

_____

SIGNATURE