INNOVATIVE FOOT & ANKLE CARE

DR. ALBERT J. KIM
DR. SUSANNA CHAN

Patient Information Form

Patient Information

Patient Name: (Mr. | Mrs. | Ms.): _____
Last First Middle

Address: _____
Street City State Zip Code

Date of Birth: ____ ____ ____ Age: ____ Sex: M | F Social Security #: _____
MONTH DAY YEAR

Home Phone: (____) _____ Work or Cell Phone: (____) _____

Employer Name: _____ Address: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____ Phone: (____) _____

Primary Care Physician (to whom reports may be sent)

Name: _____ Phone: _____

Address: _____

Referred by:

☐ Doctor -- Name:_____ ☐ Friend or Family--Name _____

☐ Web Search ☐ GroupOn ☐ Yelp ☐ Near home/work ☐ Insurance ☐ Other reason-- _____

Preferred Pharmacy:

Pharmacy Name: _____ Pharmacy Phone: (____) _____

Pharmacy Address: _____

Insurance Information

	Primary Insurance	Secondary Insurance
Insurance Company		

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered necessary in the judgment of the attending physician(s). I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. I authorize direct payment of covered benefits to the attending physician(s). I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Date _____ Signature of Responsible Party _____ Relationship, if not Patient _____

DR. ALBERT J. KIM
Foot & Ankle Clinic

Patient Medical History Form

Patient Name: _____

Podiatric History

What is the **chief complaint** for which you have come to be treated? (Include foot, toes, ankle, knees, and hip complaints.)

_____

_____

_____

Have you ever been **under the care of a Podiatrist before?**

☐ Yes ☐ No

If Yes,
Name _____

Last Visit _____

Please indicate if you **now have** or **have had problems** with any of these by marking an "**X**".

___ Ankle pain
___ Athlete's foot
___ Bunions
___ Corns and calluses
___ Cramps in feet or legs
___ Flat feet
___ Heel pain
___ Ingrown toenails
___ Injuries to the foot
___ Plantar warts
___ Swelling in ankles or feet
___ Tired feet

Your **shoe size** _____

Athletic activities in which you participate (please list and indicate frequency):

_____

_____

List **surgeries, serious injuries,** and **serious illnesses:**

_____

_____

_____

_____

_____

Allergies and Medications

Allergies and Drug Intolerance

☐ No known drug allergies

☐ Adhesive/Tape
☐ Aspirin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local anesthetics (e.g., Novocaine)
☐ Penicillin
☐ Seafood
☐ Sulfa
☐ _____

Medications you are taking (prescription, non-prescription, herbal supplements, vitamins, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please go to the next page.

DR. ALBERT J. KIM
Foot & Ankle Clinic

Patient Medical History Form

General Medical History

Your **occupation** _____

Your **height** _____

Your **weight** _____

Do you **smoke?**
☐ Yes ☐ No

Have you **ever smoked?**
☐ Yes ☐ No
How much? _____ packs / _____
Years smoked _____

Drink **alcohol?**
☐ Yes ☐ No
How much? _____

Recreational drugs?
☐ Yes ☐ No
What? _____

Pregnant or possibly pregnant?
☐ Yes ☐ No

Please indicate if **you** or a **family member now have or have had** any of the following by marking an "**X**".

	You	**Family Member**
___	Anemia	
___	Arthritis	___
	Type: _____	
___	Artificial heart valves	
___	Artificial joints	
___	Asthma	___
___	Back problems	
___	Bleed easily	___
___	Cancer	___
___	Chemical dependency	___
___	Chest pain	___
___	Circulatory problems	___
___	Diabetes	___
___	Deep vein thromboses	___
___	Epilepsy	___
___	Fibromyalgia	
___	Gout	
___	Heart disease	___

Please indicate if **you** or a **family member now have or have had** any of the following by marking an "**X**".

	You	**Family Member**
___	Heartburn, chronic	___
___	Hemophilia	___
___	Hepatitis	
___	High blood pressure	___
___	HIV/AIDS	
___	Kidney problems	___
___	Liver disease	___
___	Lung/respiratory disease	___
___	Mental illness	___
___	Phlebitis	___
___	Psoriasis	___
___	Rheumatic fever	
___	Stroke	___
___	Thyroid problem	
___	Tuberculosis	
___	Ulcers, stomach	
___	Varicose veins	
___	Venereal disease	

I certify that the above information is correct to the best of my knowledge. I give my permission to the attending physician(s) to administer and perform such procedures as may be deemed necessary for my diagnosis and treatment.

Date	Signature of Responsible Party	Relationship, if not Patient

Printed Name of Responsible Party

INNOVATIVE FOOT & ANKLE CARE

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Authorization, Assignment and Release

Initials _____**AUTHORIZATION TO RELEASE INFORMATION:** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, or doctor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you and I hereby release you of any consequence thereof.

Initials _____**ASSIGNMENT OF PAYMENT:** My insurance company is hereby requested to pay direct to Innovative Foot & Ankle Care listed below, any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

Initials _____**POSITIVE VERIFICATION OF COVERAGE CANNOT BE OBTAINED:** 1 understand that any insurance verification made on our behalf is only a rough estimate and NOT an exact verification. It is the patient's responsibility to obtain true and accurate insurance verification and exact payment required for services.

Initials _____**RESPONSIBILITY TO PAY:** I understand that I am personally responsible to pay all charges that are not covered by my insurance, including but not limited to, co-pays, deductibles, and non-covered services such as custom orthotics or any other materials dispensed in the office.

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Medicare Only

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration of its' intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits.

****

I hereby acknowledge that I am receiving (or about to receive) health care services at Innovative Foot & Ankle Care and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made by the insurance proceeds.

I further understand that I am responsible for any collection and/or legal fees incurred in the collection of any past due charges.

I understand that if it is determined that there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor then payment of services rendered by the doctor at Innovative Foot & Ankle Care will be made promptly and my bill to be paid in full.

I hereby irrevocably assign all medical payments to Innovative Foot & Ankle Care for my medical care from my insurance carriers.

I have read and understand the above. I understand my possible financial responsibility. I hereby authorize Innovative Foot & Ankle Care to release all information necessary to secure the payment of benefits. 1 hereby affix my signature as an acknowledgement of this understanding. 1 authorize a photocopy of this release and assignment as valid.

_____ _____

Patient's Signature (Parent's Signature if minor) Witness

Date: _____