Welcome

PATIENT REGISTRATION INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

WELCOME TO THE OFFICE

Please take a few minutes to complete the following medical questionnaire. It will help the doctor familiarize himself with your foot problem as well as your general health status. *"Yes, your feet are connected to the rest of your body"*

NAME _____

PLEASE DESCRIBE YOU FOOT PROBLEM/S: _____

_____

LOCATION OF PROBLEM _____

HOW LONG HAVE YOU HAD THE PROBLEM? _____

SEVERITY OF PROBLEM / PAIN: RATE 0 – 10 _____

IF YOU HAVE PAIN PLEASE DESCRIBE IT [ ] CONSTANT [ ] INTERMITTENT [ ] SHARP [ ] DULL
[ ] ACHE [ ] SHOOTING [ ] BURNING [ ] WORSE WITH THE FIRST STEP [ ] GETTING WORSE
[ ] GETTING BETTER [ ] STAYING ABOUT THE SAME

DESCRIBE: _____

WHAT MAKES THE PROBLEM WORSE? _____

WHAT MAKES THE PROBLEM BETTER? _____

IF RELATED TO AN INJURY, ACCIDENT OR WORK, PLEASE EXPLAIN:

_____

PREVIOUS MEDICAL EVALUATION OR TREATMENT [ ] NO [ ] YES _____

_____

GENERAL MEDICAL HISTORY

PRIMARY PHYSICIAN: _____ **LAST VISIT**: _____

DO YOU HAVE ANY ALLERGIES?: [ ] NO [ ] YES LIST:_____

CURRENT MEDICATIONS: [ ] NONE [ ] SEE LIST
PLEASE LIST

_____

_____

CURRENT OR RECENT MEDICAL HISTORY:

[ ] ATRIFICIAL JOINTS	[ ] DIABETES	[ ] HEART DISEASE
[ ] ARTHRITIS	[ ] FOOT WOUNDS	[ ] BLOOD THINNERS
[ ] CANCER	[ ] AUTOIMMUNE DISEASE	[ ] LIVER DISEASE
[ ] KIDNEY DISEASE	[ ] STOMACH ULCERS	[ ] STROKE
[ ] POOR CIRCULATION	[ ] HIGH BLOOD PRESSURE	[ ] ASTHMA
[ ] BLOOD CLOTS	[ ] IRREGULAR HEART BEAT	[ ] GOUT

OTHER SIGNIFICANT ILLNESSES, SURGERIES OR INJURIES _____

_____

ARE YOU PREGNANT OR BREAST FEEDING? [ ] NO [ ] YES _____
DO YOU TAKE ANTIBIOTICS BEFORE DENTAL VISITS? [ ] NO [ ] YES

NEXT

TOBACCO USE: [ ] NEVER [ ] QUIT - WHEN _____ [ ] YES - AMOUNT _____

ALCOHOL USE: [ ] NONE [ ] SOCIAL [ ] MODERATE [ ] HEAVY [ ] ALCOHOLISM [ ] FORMER ALCOHOLIC

DRUG ABUSE OR ADDICTION [ ] NO [ ] YES _____

ACTIVITY LEVEL: [ ] SEDENTARY [ ] MODERATE [ ] HEAVY [ ] SPORT / EXERCISE _____

FAMILY HISTORY: [ ] DIABETES [ ] HEART DISEASE [ ] CANCER [ ] FOOT PROBLEMS

HEIGHT _____ **WEIGHT** _____ **SHOE SIZE** _____

PLEASE MARK IF YOU ARE <u>CURRENTLY</u> EXPERIENCING ANY OF THE FOLLOWING.

___ Fever	**___ Tingling**	**___ Cold feet**	**___ Excessive thirst**
___ Chills	**___ Weakness**	**___ Leg pain with walking**	**___ Heat / cold intolerance**
___ Fatigue	**___ Tremor**	**___ Swelling**	**___ Easy bruising**
___ Skin itching	**___ Joint pain**	**___ Calf pain**	**___ Profuse bleeding**
___ Rashes	**___ Joint stiffness**	**___ Intestinal bleeding**	**___ Chest pain**
___ Open wounds	**___ Back pain**	**___ Abdominal pain**	**___ Palpitations**
___ Skin infection	**___ Sciatic pain**	**___ Heartburn**	**___ Shortness of breath**
___ Numbness	**___ Balance problems**	**___ Jaundice**	**___ Cough**

REVIEWED BY DR. _____ _____

signed date

Moulton Podiatry Group, Inc.
George J. Maraczi, D.P.M.
Matthew J. Cox, D.P.M.
30001 Town Center Dr., E-2
Laguna Niguel, CA 92677
949-495-2506

NOTICE OF PRIVACY PRACTICES

1. **This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

2. **How we may use and disclose your health information.** We use health information about you for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information you can late revoke it to stop any future uses and disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we may use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have a right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make any significant changes in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at anytime.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies or you disagree with a decision we have made about access to your health information, you may contact management.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so choose) and understand the Notice.

_____ _____
Print Patient Name Date

_____
Authorized Representative (if applicable)

X_____
Signature of Patient or Representative

2. I agree to pay for any services provided to me or requested by me or on my behalf, which are not paid by my insurance company or other party responsible for paying for my care. I also understand that I am responsible for interest and penalties, any collection costs, court costs, and reasonable attorney's fees incurred in the enforcement of this agreement.

X_____ if minor _____
Signature of patient Signature of authorized person

AUTHORIZATION TO DISCLOSE PRIVATE MEDICAL INFORMATION

1.. I authorize my physician and his associated staff to disclose my personal and private medical information to the following person(s) when deemed appropriate and necessary in the interest of providing quality healthcare to me.

_____ _____
Name (please print) Relationship

X_____ _____
Signature of Patient Date

2. Furthermore, I hereby authorize the doctors and staff to leave voice messages on my home voice mail and/or answering machine informing me of laboratory results, appointment reminder calls and information regarding the status of my insurance authorizations for referrals to specialists and/or diagnostic procedures.

_____
Name (please print)

X_____ _____
Signature of Patient Date

3. If you would like to receive medical information via email, please provide email address.

_____