



Scot L. Roberg, D.P.M., Dylan M. Roberg, D.P.M., Ana Emirzian D.P.M., Sean M. Pearson D.P.M., Steven Vines D.P.M., Anh Nguyen D.P.M

Patient Welcome Form

Today's Date: ___/___/___

Patient Name: _____

Sex: Male Female Date of Birth: ___/___/___ Marital Status: _____

Home Address: _____

Email: _____ Preferred Phone Number: _____

Social Security # _____ Drivers License # _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Referring Physician: _____ Phone Number: _____

How did you hear about us? Referral Insurance Online Doctor
 Friend/Family Other _____

Patient Height: _____ Weight: _____

DUE TO HIPPA REQUIREMENTS, PLEASE CHECK THE FOLLOWING:

- Hispanic / Latino
 - American Indian / AK Native
 - Asian
 - White
 - African American
 - Native Hawaiian / Pacific Islander
 - Other
- Primary Language: English Spanish Other: _____

Insurance Information:

All patients are asked to provide a copy of their insurance card upon check-in.

Primary Insurance Provider: _____

Policy Holder Name: _____ Policy Holder Date of Birth: ___/___/___

Preferred / Current Pharmacy:

Pharmacy Name: _____

Pharmacy Location: _____

Current Medications:

Include prescriptions, over-the-counter medications & vitamins:

(PLEASE COMPLETE BACK OF FORM)



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Patient Allergies:

- Adhesive / Tape
 - Aspirin
 - Codeine
 - Demerol
 - Iodine
- Local Anesthetics
 - Penicillin
 - Sulfa
- Other: _____

Podiatric History:

What is the reason for your appointment today? (Include foot, ankle, knee, thigh or hip complaints):

Have you ever been to a Podiatrist before? Yes No If yes, with: _____

Medical History: (Check those that apply)

- | | |
|--|--|
| AIDS/HIV <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Kidney Problems <input type="checkbox"/> |
| Bleeding Disorders <input type="checkbox"/> | Liver Disease <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Neuropathy <input type="checkbox"/> |
| Circulatory Problems <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Ulcers <input type="checkbox"/> |
| Gout <input type="checkbox"/> | Varicose Veins <input type="checkbox"/> |
| Hepatitis or Jaundice <input type="checkbox"/> | Cigarette/Tobacco Use? Years: _____ |

Please indicate which foot problems you have had in the past:

- | | |
|---|--|
| Ankle Pain <input type="checkbox"/> | Foot or Leg Cramps <input type="checkbox"/> |
| Athlete's Foot <input type="checkbox"/> | Heel Pain <input type="checkbox"/> |
| Bunions <input type="checkbox"/> | Ingrown Toenails <input type="checkbox"/> |
| Corns and Calluses <input type="checkbox"/> | Plantar Warts <input type="checkbox"/> |
| Cramps or Numbness <input type="checkbox"/> | Swelling in Ankles/Feet <input type="checkbox"/> |
| Flat Feet <input type="checkbox"/> | |

Treatment Consent:

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent or Guardian

Date

Print Name of Signature Above

Date



Consent for Medical Treatment and Release of Information

- 1. **Consent for Health Care Services:** I authorize consent for medical treatment at Coastal Foot and Ankle
- 2. **Authorization of Release of Information:** Coastal Foot and Ankle may release information from my medical records to any health care provider involved in my care and treatment. Coastal Foot and Ankle may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer’s workers’ compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Coastal Foot and Ankle is no longer responsible for the confidentiality of any information known or possessed by the payer.
- 3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Coastal Foot and Ankle which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Coastal Foot and Ankle. I understand that I am responsible for a \$45.00 returned check fee in addition to any other associated bank charges.
- 4. **Pre-authorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Coastal Foot and Ankle charges.
- 5. **Assignment for Direct Payments:** I authorize that payment of insurance (including auto insurance and health-care insurance) benefits for health care services of goods may be made directly to Coastal Foot and Ankle.
- 6. **Charge for No Show/Cancellation without 24-hour notice:** I understand that 24-hour notice is required for canceling an appointment, and I will be charged a \$25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

The following person (or class of persons) have my authorization to access my Protected Health Information

(Name & Relationship)

(Name & Relationship)

I acknowledge that:

- I have read this form and understand its contents.
- I am the patient, or persons duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept these terms.
- Throughout my treatment, I am responsible for notifying the physicians and/or medical staff of any and all updates to the information listed or any insurance changes.
- I am responsible for the payment and/or co-payment that is due at the time of service.
- I have reviewed and understand that I may obtain a copy of the HIPPA Policy, upon request.

Signature of Patient of Legally Responsible Person

Patient Name (Please Print)

Name of Parent of Authorized Representative (if applicable)

Date