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

Patient Welcome Form

Today's Date: ____/_____/_____

Patient Name:_____
Sex: Male ▢ Female ▢ Date of Birth: ____/_____/____ Marital Status:_____
Home Address: _____
City:_____Zip:_____ Unit / Apt #: _____
Preferred Phone Number: (____)_____Please Circle: Cell or Home
Social Security Last 4 # _____Occupation:_____

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone Number: _____

Primary Care 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: _____
▢ None

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 ▢
Arthritis ▢
Bleeding Disorders ▢
Cancer ▢
Circulatory Problems ▢
Diabetes ▢
Gout ▢
Hepatitis or Jaundice ▢
High Blood Pressure ▢
Kidney Problems ▢
Liver Disease ▢
Neuropathy ▢
Stroke ▢
Ulcers ▢
Varicose Veins ▢
Cigarette/Tobacco Use? Years: ____

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

Ankle Pain ▢
Athlete's Foot ▢
Bunions ▢
Corns and Calluses ▢
Cramps or Numbness ▢
Flat Feet ▢
Foot or Leg Cramps ▢
Heel Pain ▢
Ingrown Toenails ▢
Plantar Warts ▢
Swelling in Ankles/Feet ▢

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

451 W. Gonzales Road, Suite 260 Oxnard, CA 93036 - (805) 983-0222 - Fax - (805) 604 - 9872
3160 Telegraph Road, Suite 207 Ventura, CA 93003 - (805) 485-6708 - Fax - (805) 278 - 2299

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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