



Scot L. Roberg, DPM, Dylan M. Roberg, DPM, Anh Nguyen DPM,
Sean M. Pearson DPM, Ana Emirzian DPM

Patient Welcome Form

Today's Date: ___/___/___

Patient Name: _____
Sex: Male Female Date of Birth: ___/___/___ Marital Status: _____
Home Address: _____
Unit / Apt #: _____ City: _____ Zip: _____
Preferred Phone Number: (____) _____ Please Circle: Cell or Home
Do you opt into receiving text messages from Coastal Foot and Ankle?
Social Security # _____ Occupation: _____

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

I give authorization for this contact to have access to my health information.

Primary Care Physician: _____ Phone Number: _____

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

Patient Height: _____ Weight: _____

Primary Language:

English Spanish Other: _____

Insurance Information:

It is the patient's/subscriber's responsibility to ensure that Coastal Foot and Ankle receives the most current active insurance information. Please notify our staff if your insurance information has changed.

Primary Insurance Provider: _____
Policy Holder Name: _____ Policy Holder Date of Birth: ___/___/___

Preferred / Current Pharmacy:

Pharmacy Name: _____
Pharmacy Location: _____

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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Current Medications:

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

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: (circle on picture problem area)

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"/> | |

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Treatment Consent and Financial Agreement

I consent to medical care and treatment provided by Coastal Foot and Ankle, including any procedures the physician or authorized staff deem medically necessary.

Use of Technology and Artificial Intelligence (AI):

I acknowledge that Coastal Foot and Ankle may use technology, including artificial intelligence (AI), for clinical documentation, administrative support, and decision assistance. Such tools support, but do not replace, the provider's independent medical judgment. The provider remains solely responsible for all medical decisions and care.

Authorization for Release of Information:

I authorize Coastal Foot and Ankle to disclose my medical information as necessary for treatment, payment, and healthcare operations.

Insurance Information and Financial Responsibility:

- Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your policy's terms and conditions.
- Coastal Foot and Ankle will attempt to verify eligibility and benefits as a courtesy; however, we cannot obtain exact payment details until billed.
- I am responsible for providing complete and accurate insurance information and obtaining required referrals. Failure to do so may result in claim denials, for which I accept full financial responsibility.

Payment Terms:

- Copayments & Deductibles: Copayments are due at the time of service; we cannot legally waive these. If your plan has a deductible, you will be asked to pay at the time of service until the deductible set by your carrier has been met.
- General Charges: I agree to pay all charges not covered by insurance. Payment is due upon receipt of billing.
- Returned checks are subject to a \$45 fee.

Office Policies:

- Appointments: We maintain a 15-minute late policy. If you are more than 15 minutes late, we may have to reschedule your appointment.
- Cancellations: I agree to provide at least 24-hour notice for cancellations. Failure to do so may result in a \$25 missed appointment fee, which is not billable to insurance.
- Medications: Prescriptions are sent electronically at the end of the morning or the end of the business day. Please contact your pharmacy on file directly for updates.
- A fee of \$25 will be charged for the copying and release of medical records (please allow up to 10 business days for processing).

Acknowledgment and Agreement

Signature: _____ Date: _____ Printed Name: _____

Signing on behalf of patient (under 18): _____

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