

# University Podiatry Group

DATE \_\_\_\_\_

Alan M. Singer DPM  
Robert K. Lee DPM  
Gary R. Dorfman DPM

Brendan M. Riley DPM  
Ottoniel A. Mejia DPM

UCLA MRN:

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PATIENT INFORMATION				
LAST NAME		FIRST NAME		M.I.
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE		WORK PHONE	CELL PHONE	
SEX M F	AGE	DATE OF BIRTH	MARITAL STATUS S M D W	
E-MAIL ADDRESS		DRIVER LICENSE NUMBER	SOCIAL SECURITY NUMBER	
HOW DID YOU HEAR ABOUT OUR OFFICE?		REFERRING PHYSICIAN	REFERRING PHYSICIAN'S PHONE NUMBER	

INSURANCE INFORMATION		
	PRIMARY	SECONDARY
INSURANCE COMPANY	_____	_____
NAME OF INSURED	_____	_____
INSURED DATE OF BIRTH	_____	_____
INSURED EMPLOYER	_____	_____
POLICY NUMBER	_____	_____
GROUP NUMBER	_____	_____

## PATIENT INFORMATION ACKNOWLEDGEMENT STATEMENT:

I have read and fully understand University Podiatry Group, Inc's Notice of Information Practices. I understand that University Podiatry Group, Inc. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operation if I notify the practice. I also understand that University Podiatry Group, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in University Podiatry Group, Inc's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
PLEASE PRINT NAME

**PAST MEDICAL HISTORY**

	Yes	No		Yes	No
ARTHRITIS _____	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES _____	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL JOINTS _____	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS A / B / C _____	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA/BRONCHITIS/COPD _____	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE _____	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING ABNORMALITIES _____	<input type="checkbox"/>	<input type="checkbox"/>	POOR CIRCULATION _____	<input type="checkbox"/>	<input type="checkbox"/>
BACK PROBLEMS _____	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC/PSYCHOLOGICAL CARE _____	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE _____	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD CLOTS _____	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK OR STROKE _____	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV INFECTION _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

**MEDICATIONS**

MEDICATION	INDICATION	MEDICATION	INDICATION
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

**ALLERGIES**

**SOCIAL HISTORY**

NONE THAT I KNOW OF <input type="checkbox"/>  PENICILLIN _____ Yes <input type="checkbox"/> No <input type="checkbox"/> NSAIDS/ASPIRIN _____ Yes <input type="checkbox"/> No <input type="checkbox"/> SULFA DRUGS _____ Yes <input type="checkbox"/> No <input type="checkbox"/> LOCAL ANESTHETICS _____ Yes <input type="checkbox"/> No <input type="checkbox"/> ADHESIVE TAPE _____ Yes <input type="checkbox"/> No <input type="checkbox"/> IODINE ON SKIN _____ Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____	<b>OCCUPATION</b>		<b>MARITAL STATUS</b>		
			S      M      D      W		
	<b>DO YOU SMOKE? (Circle One)</b>		<b>DO YOU DRINK ALCOHOL? (Circle One)</b>		
	YES      NO		YES      NO		
	<b>HOW MANY PACKS PER DAY?</b>		<i>(circle one if you answered yes above)</i>		
<b>HOW MANY YEARS HAVE YOU SMOKED?</b>		DAILY			
		OCCASIONALLY			
		SOCIALLY			

**REVIEW OF SYSTEMS**

**FAMILY HISTORY**

	Yes	No	<b>DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING CONDITIONS?</b>	
FEVERS _____	<input type="checkbox"/>	<input type="checkbox"/>		
CHILLS _____	<input type="checkbox"/>	<input type="checkbox"/>		
NAUSEA _____	<input type="checkbox"/>	<input type="checkbox"/>		
VOMITING _____	<input type="checkbox"/>	<input type="checkbox"/>		
TINGLING IN FOOT _____	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
BURNING IN FOOT _____	<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE _____	<input type="checkbox"/> <input type="checkbox"/>
ITCHING _____	<input type="checkbox"/>	<input type="checkbox"/>	STROKE _____	<input type="checkbox"/> <input type="checkbox"/>
RASH _____	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE _____	<input type="checkbox"/> <input type="checkbox"/>
			CANCER _____	<input type="checkbox"/> <input type="checkbox"/>
			Other: _____	

**LIST ALL THE SURGERIES YOU HAVE HAD**

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

# Billing Policy

# University Podiatry Group

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Gary R. Dorfman DPM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

## University Podiatry Group Billing Policy

Due to changes in healthcare that have decreased physician reimbursements and increased the clerical and administrative work required to secure payment for medical services rendered, the University Podiatry Group has decided to change its billing policy for the collection of co-payments and payment balances, ***effective January 1<sup>st</sup>, 2009.***

The University Podiatry Group will no longer send invoices to patients for balances or co-payments. We will require a credit card number to be kept on file. When the Explanation of Benefits (EOB) paperwork is received from your insurance company, which indicates the amount that the patient is responsible for (i.e. co-payments, deductibles, etc.), your credit card will be directly charged for those fees. ***You will ONLY be charged for amounts that your insurance company has determined to be the patient's responsibility.***

Another option is for the patient to pay for the services rendered at the time of the visit by cash, check or credit card. If and when the insurance company makes its payment to us, a reimbursement will be forwarded to you in a prompt manner.

As a courtesy to our patients, we will continue to bill insurance companies for services provided by our doctors.

Thank you for your understanding and compliance with our office policies.

Sincerely,

***The Doctors of the University Podiatry Group***

### OPTION 1: AUTHORIZATION TO CHARGE CREDIT CARD

I have read the above policy and authorize the University Podiatry Group to keep my signature on file and to charge my credit card for the balance of charges to my account (deductibles, co-payments, and non-covered services) ***NOT*** paid by my insurance.

<b>CREDIT CARD</b>  <input type="checkbox"/> VISA <input type="checkbox"/> MASTER CARD <input type="checkbox"/> AMERICAN EXPRESS	<b>CREDIT CARD NUMBER</b>	<b>EXPIRATION DATE</b>
	<b>PRINTED NAME ON CARD</b>	
<b>3 DIGIT SECURITY CODE</b>	<b>CARDHOLDERS AUTHORIZATION SIGNATURE</b>	

### OPTION 2: PAYMENT ON DATE OF SERVICE

I have read the above policy and choose to pay for all services rendered at the time of my visit with the doctor.

<b>PATIENT SIGNATURE</b>	<b>DATE</b>
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# Patient Foot/Ankle Questionnaire

# University Podiatry Group

Alan M. Singer DPM

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Gary R. Dorfman DPM

NAME \_\_\_\_\_ DATE \_\_\_\_\_

WHAT BRINGS YOU INTO THE OFFICE TODAY?			<b>DESCRIBE YOUR PAIN</b> THERE IS NO PAIN <input type="checkbox"/>  ACHE <input type="checkbox"/> DULL <input type="checkbox"/> SHARP <input type="checkbox"/> STABBING <input type="checkbox"/> POUNDING <input type="checkbox"/> THROBBING <input type="checkbox"/>	<b>HOW MUCH OF THE DAY DO YOU STAND/WALK?</b>  10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90-100% <input type="checkbox"/>
WAS THERE AN INJURY? <b>YES      NO</b>	WHEN WAS YOUR INJURY?	WHEN DID IT START? <i>(if no injury)</i>		
DOES THE PAIN OCCUR ONLY WITH CERTAIN ACTIVITIES? YES NO <i>(please explain)</i>				
WAS THERE A CHANGE IN ACTIVITY OR SHOES WHEN SYMPTOMS BEGAN? YES NO				

WHERE IS YOUR PAIN			
RIGHT FOOT		LEFT FOOT	
			
			

<b>HAVE YOU NOTICED ANY:</b>  REDNESS <input type="checkbox"/> BRUISING <input type="checkbox"/> SWELLING <input type="checkbox"/> DISCOLORATION <input type="checkbox"/> DRAINAGE/BLEEDING <input type="checkbox"/>	<b>DO YOU HAVE DIFFICULTY:</b>  WALKING <input type="checkbox"/> RUNNING <input type="checkbox"/> CLIMBING <input type="checkbox"/> SQUATTING <input type="checkbox"/> WITH STAIRS <input type="checkbox"/>	<b>LIST PREVIOUS TREATMENTS:</b>  CASTING <input type="checkbox"/> BRACING <input type="checkbox"/> STRAPPING <input type="checkbox"/> CORTISONE SHOTS <input type="checkbox"/> PHYSICAL THERAPY <input type="checkbox"/>	<b>WHAT MAKES IT FEEL BETTER:</b>  ICE <input type="checkbox"/> REST <input type="checkbox"/> ELEVATION <input type="checkbox"/> ALEVE/ADVIL <input type="checkbox"/> CERTAIN SHOES <input type="checkbox"/>
OTHER: _____	OTHER: _____	OTHER: _____	OTHER: _____

DO YOU USE CUSTOM ORTHOTICS <b>YES      NO</b>	IF YES, HOW LONG HAVE YOU WORN THEM?	DO THEY HELP? <b>YES      NO</b>
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DO YOU EXERCISE REGULARLY? <b>YES      NO</b>	WHAT KIND OF EXERCISE DO YOU DO?	HOW OFTEN DO YOU EXERCISE?
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DO YOU HAVE ANY OTHER PERTINENT THINGS TO MENTION ABOUT THIS PROBLEM?

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