

# University Podiatry Group

DATE \_\_\_\_\_

Alan M. Singer DPM  
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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		
			DO YOU SMOKE? <i>(Circle One)</i>	DO YOU DRINK ALCOHOL? <i>(Circle One)</i>	
			YES      NO	YES      NO	
			<b>HOW MANY PACKS PER DAY?</b>	<i>(circle one if you answered yes above)</i>	
			DAILY		
		<b>HOW MANY YEARS HAVE YOU SMOKED?</b>	OCCASIONALLY		
			SOCIALLY		

**REVIEW OF SYSTEMS**

**FAMILY HISTORY**

	Yes	No	DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING CONDITIONS?	
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. _____