



Patient Demographic Form

Please Print Legibly

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security Number: _____ Gender: Male Female Other

Home Address: _____

STREET	CITY	STATE	ZIP
Mailing Address: _____			

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Marital Status: Single Widowed Married Separated Divorced Other

Race: White – Non-Hispanic Native America Hispanic Other African American (Optional)

Employment Status: Employed Student Not Employed Other

Employer: _____

EMERGENCY CONTACT

Name: _____ Phone Number: _____ Relationship to you: _____

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician: _____ Date of most recent visit: _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Self (Skip to Primary Insurance) Spouse Other Parent Date of Birth: _____

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

Home Phone Number: _____ Cell Phone Number: _____

PRIMARY INSURANCE

Primary Insurance Company: _____ Policy No: _____ Group No: _____

Subscriber's Name: _____ Date of Birth: _____

SECONDARY INSURANCE

Secondary Insurance Company: _____ Policy No: _____ Group No: _____

Subscriber's Name: _____ Date of Birth: _____

Printed Name: _____

Signature: _____

Date: _____

Medical History Intake Form



Patient Name: _____ Date of Birth: _____

Pharmacy

Pharmacy Name: _____ Location: _____

Medical History (check if diagnosed at any time)

- | | | | |
|-----------------------------------------------|----------------------------------------------|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Alzheimer's/dementia | <input type="checkbox"/> COPD | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke |

Other conditions not listed above? _____

History of diabetes? If no, please skip to the next section

- | | | |
|----------------------------------|--------------------------------|-------------------------------------------|
| <input type="checkbox"/> Type I | Date of most recent A1C: _____ | <input type="checkbox"/> Diet & Exercise |
| <input type="checkbox"/> Type II | HbA1C level: _____ | <input type="checkbox"/> Insulin |
| | | <input type="checkbox"/> Oral medications |

- Diabetic Complications? Foot Ulceration Kidney Problems Loss of vision
 Peripheral Neuropathy Amputation(s) Other: _____

Medication List

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Alcohol No Yes # Drinks per week: _____ Recreational Drugs: _____ Quit date: _____

Tobacco No Yes Type: _____ Started at age: _____ Trying to quit? No Yes

Allergies and Reaction	Major Surgeries and estimated Date

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the podiatry office of any changes in medical status.

Patient or Guardian Signature: _____ Date: _____



COMMUNICATION CONSENT FORM

I consent to Stephanie Gonzalez, DPM, PA to contact me in relation to my care by the following:

Home Phone Number: _____ **Cell Phone Number:** _____

I understand that during the transmission of these messages, the information contained in one point, or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure. However, the practice will not transmit any personal or confidential information about your health, procedures, or account status without your permission. I agree to inform the practice if my telephone numbers and/or email address change. I understand and acknowledge that I can cancel this consent at any time.

I hereby acknowledge that I have read and understood the Communication Consent

Patient Name: _____

Signature: _____

IMAGES CONSENT

If you would like to consent to Stephanie Gonzalez, DPM, PA for the use of photographs or electronic media images in any presentation of all kinds whatsoever please select from the options below. You may revoke this authorization at any time by notifying the office staff in writing. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept if they are relevant and after that time destroyed.

Please initial and continue to sign and date,

_____ I hereby grant Stephanie Gonzalez, DPM, PA, permission to use any photograph(s) or electronic media images taken in my visit.

_____ I do **NOT** give Stephanie Gonzalez, DPM, PA, permission to use any photograph(s) or electronic media images taken during any visit.

Signature: _____

CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care, including routine procedures and other treatment by professionals and their assigns, appointees as is necessary in their judgment.
2. I acknowledge that no guarantees have been made to me as the result of treatments or examinations.
3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Furthermore, if I do not fully understand a procedure or its risks, consequences, and alternate methods of treatment I have the right to question the appropriate professional.

I hereby acknowledge that I have read and understood the Consent for Treatment.

Signature: _____ **Date:** _____



Agreement of Financial Responsibility

Thank you for choosing our office for your Podiatry care. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please remember that payment is your responsibility regardless of insurance.
- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, and credit cards.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. **Should you fail to provide this information, you will be financially responsible.**
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient



Appointment Policy

Thank you for choosing Stephanie Gonzalez, DPM, PA for your podiatric care. Due to a long waiting list of new patients and a high volume of no call no shows, we are requiring patients to have their card information on file. A \$25.00 fee will be charged for cancellations/reschedules that do not give a 24-hour notice, and for no shows. **THIS PAYMENT WILL NOT BE CHARGED UNLESS THE PATIENT NO SHOWS OR DOES NOT GIVE A 24 HOUR NOTICE FOR A CANCELLATION/RESCHEDULE.**

By voluntarily signing below, I show that I have read, understand, and agree to the information stated above.

Patient or Legal Guardian Print _____

Patient or Legal Guardian Signature _____ Date _____

Credit Card Information

Credit Card #: _____

Expiration Date: _____

Billing Zip Code: _____



Notice of Privacy Practices

Our practice is required by law to maintain the confidentiality of your health information. As a result, we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:

1. Public health authorities and health oversight facilities.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by law enforcement.
4. If you are a member of U.S. or foreign military forces (including veterans).
5. For Workers Compensation and similar programs.
6. When the medical staff is requesting prior authorizations for continuation of medical treatment.
7. To reduce or prevent a serious threat to your health and safety of others in certain situations.

Your rights regarding your health information:

1. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information of only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
2. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records at a fee of \$40.00. You must submit your request in writing to your physician.
3. You may revoke this consent of your Protected Health Information in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.
4. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time.
5. Right to provide an authorization for others uses and disclosures: our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have read and understood the Notice of Privacy Practices and give my permission to use and disclose my health information.

Signature of Patient or Legally Authorized Individual

Date

Print Patient's Full Name

Date