

PODIATRIC REGISTRATION AND HISTORY

1**PATIENT INFORMATION**

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: ___ M ___ F Age _____ Birthdate _____

Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____

How did you hear about us?
_____**2****CONTACT INFORMATION**

Email _____

Telephone Information:

Home _____ Work _____ Ext _____

Mobile _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Telephone Information:

Home _____ Work _____

3**INSURANCE**

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes ___ No ___

Subscriber Name _____

Birthdate _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

4**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

5**PODIATRIC HISTORY**

What is the chief complaint for which you to be treated (Include foot, ankle, knee hip, thigh complaints)

Have you ever been to a Foot Doctor before? ___ Yes ___ No

Name _____

Last Visit _____

Is there any personal or family history of diabetes? ___ Yes ___ No

Cigarette/Tobacco use _____

Years Smoked _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

Ankle Pain _____ Athlete's Foot _____

Bunions _____ Corns & Callouses _____

Numbness in Feet or Legs _____

Flat Feet _____ Foot /Leg Cramps _____

Heel Pain _____ Ingrown Toenails _____

Plantar's Warts _____ Tired Feet _____

Swelling in Ankles or Feet _____

6 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	—	—	Diabetes	—	—	Psychiatric Care	—	—
Allergies to Anesthetics	—	—	Ear Problems	—	—	Radiation Treatment	—	—
Allergies to Medicine	—	—	Epilepsy	—	—	Rash	—	—
or Drugs	—	—	Eye Problems	—	—	Respiratory Disease	—	—
Anemia	—	—	Fainting	—	—	Rheumatic Fever	—	—
Angina	—	—	Foot or Leg Cramps	—	—	Shortness of Breath	—	—
Arthritis	—	—	Gout	—	—	Sinus Problems	—	—
Artificial Heart Valves	—	—	Headaches	—	—	Special Diet	—	—
or Joints	—	—	Heart Disease	—	—	Stroke	—	—
Asthma	—	—	Hemophilia	—	—	Swelling in Ankles, Feet	—	—
Back Problems	—	—	Hepatitis or Jaundice	—	—	Swollen Neck Glands	—	—
Bleeding Disorders	—	—	High Blood Pressure	—	—	Tired Feet	—	—
Cancer	—	—	Kidney Problems	—	—	Tuberculosis	—	—
Chemical Dependency	—	—	Liver Disease	—	—	Ulcers	—	—
Chest Pain	—	—	Low Blood Pressure	—	—	Varicose Veins	—	—
Chronic Diarrhea	—	—	Nervous Problems	—	—	Venereal Disease	—	—
Circulatory Problems	—	—	Phlebitis	—	—	Weight Loss, unexplained	—	—
Height _____			Weight _____					
Past Surgeries								

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? _____ Yes _____ No

If yes, please explain _____

7 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins.

Pharmacy

Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? _____ Yes _____ No

8 ALLERGIES

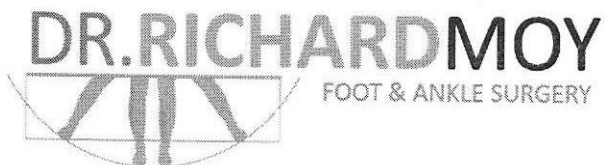
— Adhesive/Tape	— Local
— Anticoagulant	— Novocaine
— Therapy	— Penicillin
— Aspirin	— Seafoods
— Codeine	— Sulfa
— Demerol	— Iodine

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____



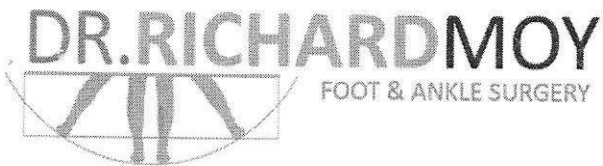
29300 Portola Parkway, Ste B
Lake Forest, Ca 92630
P: (949)837-3338
F: (949)716-2725
DrMoy.com

RICHARD R MOY DPM INC
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of the "Notice of Privacy Practices", as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient's Signature

Date



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Cost for Medical Records

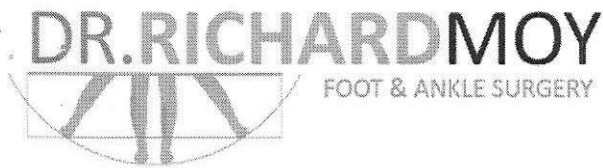
We charge a fee for medical records to cover the costs of copying, mailing and/or other supplies associated with your request. Upon receiving your request, we will inform you of the fee.

1-10 pages	\$10.00
Additional pages postage <i>*rates vary based on size of medical record</i>	\$0.50 per page
X-rays or diagnostic imaging	\$10.00

Patient Name (Printed)

Patient or Responsible Party Signature

Date



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History of Foot Problems

Patient Name: _____

Date: _____

ONSET

1. When did the pain start? *e.g. 1 week, 1 month, 1 year*

NATURE OF PAIN:

2. What kind of pain or pains are you having? *e.g. sharp, dull, shooting, stabbing aching, radiating, diffuse, constant, intermittent*

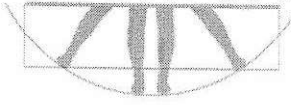
LOCATION:

3. Where is the pain? *e.g. right or left foot, toes, top/bottom of foot, arch, heel, ankle, toenails*
4. What symptoms do you have? *e.g. swelling, redness, bruising, burning, itching, numbness, discolored nails, skin flaking, bumps, tiredness, cramping*

PAST TREATMENT:

5. Self – What have you done to alleviate pain? *e.g. rest, ice, medication, change activities, change shoes*
6. Professional – Have you seen anyone for this problem? What did they do for you? What advice or treatment was given?

DR. RICHARD MOY



FOOT & ANKLE SURGERY

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FOOTWEAR:

7. What shoes can you wear? *e.g. tennis shoes, heels, boots*

8. What shoes do you avoid and why? *e.g. tennis shoes, boots, heels*

WORK/RECREATION

9. How has this affected your work, if at all?

10. How has this affected your recreational activities? *e.g. stopped running, skiing, walking, etc.*

Patient or Responsible Party Signature

Date