WELCOME

PATIENT INFORMATION:

TODAY'S DATE:____

PATIENT SOC. SEC. # ____ (IF MINOR, ADD PARENT'S SOC. SEC. #)

LAST, FIRST NAME:____

ADDRESS:____

CITY :____ **STATE:**______________ **ZIP:**_________________________

PHONE #:___________________________**CELL #:**___________________________**OTHER #:**________________________

EMPLOYER NAME: ____ **WORK #:**_____________________________

YOUR OCCUPATION: _________________________________ **REFERRED BY:**____________________________________

GENDER: MALE / FEMALE AGE:_______________ **DATE OF BIRTH:** ____________________________________

MARRIED WIDOWED SINGLE MINOR SEPARATED DIVORCED

RACE:____________________ **ETHNICITY:**____________________ **LANGUAGE PREFERRED:** ____________________
(Idioma que prefiere)

EMERGENCY CONTACT & PHONE #:____
(Nombre y telefono de Emergencia)

WHAT IS THE REASON FOR YOUR VISIT?: (¿Cuál es el motivo de su visita)

____

____

FAMILY DOCTOR:____ **PHONE #:** _______________________________
(Su Doctor Familiar)

MEDICATIONS & STRENGTH(MEDICAMENTOS Y DOSIS)**: (INCLUDING PRESCRIPTIONS, + OVER-THE-COUNTER MEDICATIONS)**

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ALLERGIES:(ALERGIA)____

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<u>LA NORMA DE ESTE CONSULTORIO ES LA SI GUIENTE:</u> SI FALTA A SU CITA O NO RECIBIMOS SU LLAMADA TELEFONICA 24 HRS. PREVIO A LA CITA INDICADA, SE LE COBRARAN $40.00 DLLS. PROCURE LLEGAR A TIEMPO A SU CITA, DE LO CONTRARIO NOS VEREMOS EN LA NECESIDAD DE HACERLE UNA NUEVA CITA. X___________ (PONGA SUS INICIALES AQUI)

<u>APPOINTMENT NO SHOW POLICY:</u> OUR APPOINTMENT NO SHOW POLICY REQUIRES 24 HOUR CANCELLATION PRIOR TO YOUR APPOINTMENT. THERE WILL BE A $40.00 (OFFICE VISIT) FOR EACH NO SHOW. IF YOU ARE LATE FOR YOUR APPOINTMENT THERE IS A POSSIBLITY YOU MAY BE RESCHEDULED. X____________ (INITIAL HERE)

MEDICAL HISTORY:

CIRCLE "YES OR NO " TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

AIDS / HIV (SIDA)	**YES**	**NO**
ANTICOAGULANT THERAPY (TERAPIA DE ANTICOAGULANTE)	**YES**	**NO**
ALLERGIES TO MEDICINES/DRUGS (ALERGIAS A MEDICACION)	**YES**	**NO**
ARTHRITIS	**YES**	**NO**
ASTHMA (ASMA)	**YES**	**NO**
BLEEDING DISORDERS (TRASTORNOS DE SANGRADO)	**YES**	**NO**
CANCER	**YES**	**NO**
CHEMICAL DEPENDANCY (LA DEPENDENCIA QUIMICA)	**YES**	**NO**
CIRCULATORY PROBLEMS (PROBLEMA A CIRCULATORIO)	**YES**	**NO**
DIABETES	**YES**	**NO**
GOUT (GOTA)	**YES**	**NO**
HEART DISEASE (ENFERMEDAD DEL CORAZON)	**YES**	**NO**
HIGH BLOOD PRESSURE (ALTA PRESION)	**YES**	**NO**
KIDNEY PROBLEMS (PROBLEMAS DE RINON)	**YES**	**NO**
LIVER DISEASE (ENFERMEDAD DEL HIGADO)	**YES**	**NO**
RESPIRATORY DISEASE (ENFERMEDAD RESPIRATORIA)	**YES**	**NO**
STROKE (EMBOLIA)	**YES**	**NO**

Surgical History (Historial de Sirugias**):**

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Family History-List any serious medical conditions in your immediate family: ________________________
(Historial familiar de sus condiciones medicas)

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Have you ever smoked? Yes / No Date Began: _________________ Date Quit:___________________
(A fumado alguna vez)

Do you drink alcohol? Yes / No

Do you use recreational drugs? Yes / No

INSURANCE ASSIGNMENT & RELEASE:
I CERTIFY THAT I HAVE COVERAGE WITH ______________________________ AND ASSIGN DIRECTLY TO SOUTH BAY FOOT & ANKLE SPECIALIST INC ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIAL RESPONSIBLE FOR ALL CHARGES WHEATHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.
THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE INSURED COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES.

I HEREBY CONSENT AND GIVE MY PERMISSION TO THE DOCTOR AND HIS ASSISTANT'S TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY

X____**DATE:**________________
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

____ ________________________
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**