When complete, email this form to office@bayareapod.com

You may also print the completed form and bring it with you to your appointment.

BAY AREA PODIATRY GROUP

Surgical and Non-Surgical Foot/Ankle Care

New Patient Registration

Part 1 of 2 · Patient Information, Insurance & Consents

Please complete all sections and print clearly. Thank you!

¿Prefiere este formulario en español? Pídale una copia a la recepción.

Patient Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | Age

Patient Information

Preferred Name | Preferred Language | Race / Ethnicity

Street Address

City | State | ZIP Code

Phone Cell Home | Email

Preferred contact: ☐ Call ☐ Text ☐ Email **Sex:** ☐ Male ☐ Female ☐ Other:

OK to leave detailed messages? Voicemail ☐ Yes ☐ No Text ☐ Yes ☐ No

Employment

Employer | Occupation

Work Phone | City

Emergency Contact

Name | Relationship to Patient | Phone

Insurance Information

Primary Insurance

Insurance Company | Member / ID # | Group #

Subscriber Name | Subscriber Date of Birth | Relationship to Patient

Secondary Insurance (if any)

Insurance Company | Member / ID # | Group #

Subscriber Name | Subscriber Date of Birth | Relationship to Patient

How Did You Hear About Us?

Referral source: ☐ Physician ☐ Internet ☐ Friend / Family ☐ Other:

If referred, whom may we thank?

Authorization to Release Medical Information

I: ☐ Authorize ☐ Refuse

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, including claims for disability benefits, insurance applications, and prescriptions. I authorize the transmission of medical information by fax.

Patient / Guardian Signature | Date

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have received (or had the opportunity to receive) and have read and understood the Notice of Privacy Practices.

Patient / Guardian Signature | Date

☐ **Electronic Signature Agreement**

By checking this box, I agree that typing my name on the signature lines of this form constitutes my electronic signature and has the same legal effect as a handwritten signature.

Completed forms: email to office@bayareapod.com · or bring a printed copy to your appointment

Consents & Acknowledgments

Please read each section, initial where indicated, and sign below.

Initials _____

1. Treatment Consent

I consent and give permission to the doctor (and the doctor's assistants or designated replacements) to administer and perform such procedures as the doctor deems necessary. I authorize the doctor or their assistants to diagnose and treat my condition with x-rays, examination, photographs, or injections as necessary.

Initials _____

2. Media Consent

I consent to photography, filming, videotaping, and/or audio recording or other means of capturing my image or voice for purposes deemed necessary by the doctor for treatment of my foot condition and/or marketing. These media will be handled in accordance with HIPAA regulations.

Initials _____

3. Acceptance of Financial Responsibility

I understand that I am responsible for any or all parts of my account not paid by my insurance company. I authorize the release of medical information necessary to process claims. I agree to pay my co-payment before receiving treatment.

Initials _____

4. No-Show / Cancellation Policy

- At least 24 hours' advance notice is required to cancel. If you cannot keep your appointment, we are happy to reschedule it for you.
- Failure to give 24-hour notice results in a non-refundable $35.00 administrative charge per visit. This fee is not covered by insurance.
- If you miss 3 appointments without paying the owed amount, or no-show twice, you may be discharged from the practice.

Patient Name (print) _____

Patient / Guardian Signature _____ Date _____

Non-Covered Custom Orthotics Disclaimer

The custom orthotic products we offer may or may not be covered by your insurance plan. Coverage varies by plan and from year to year. You are responsible for any portion of the cost not covered by insurance, and for understanding how that cost applies to your deductible. You may contact your insurance provider to verify coverage before purchasing, or our team can provide information. Either way, payment responsibility rests with the patient. All sales are final and non-refundable.

Patient / Guardian Signature _____ Date _____

☐ **Electronic Signature Agreement**

By checking this box, I agree that typing my name on the signature lines of this form constitutes my electronic signature and has the same legal effect as a handwritten signature.

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New Patient Registration

Part 2 of 2 · Medical History

This part goes to the exam room with your medical assistant.

Patient Name (Last, First, MI) _____ Date of Birth (mm/dd/yyyy) _____ Age _____

Reason for Today's Visit

Please describe the problem that brings you in today

_____

_____

How long have you had this problem? _____ Date of injury (if any) _____

Did you experience an injury? ☐ No ☐ Yes **Is it work related?** ☐ No ☐ Yes

Describe your pain (check all that apply)

☐ No pain ☐ Sharp ☐ Dull ache / sore

☐ Throbbing ☐ Stiff ☐ Radiating / "electric"

☐ Pins & needles ☐ Burning / itching ☐ Other

Rate your pain (circle or check one)

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst

What have you tried for treatment?

_____

What makes it better? _____ What makes it worse? _____

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Orinda • 3 Santa Maria Way, Orinda, CA 94563 • 925.253.1414 • Fax 925.253.9424

Primary Care & Pharmacy

Primary Care Physician

PCP Phone

PCP Address

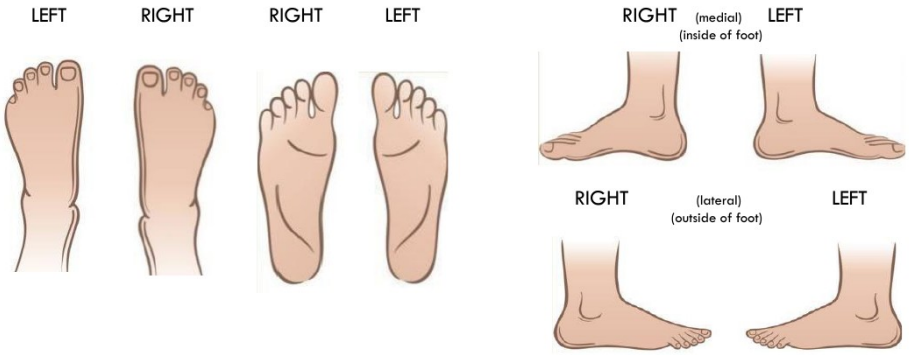
Preferred Pharmacy

Pharmacy Phone

May we share information about this visit with your doctor? ☐ Yes ☐ No

Where Does It Hurt?

Circle or shade the areas where you feel pain. Note L (left) or R (right) if needed.



Height

Weight

Shoe Size

Current Medications

☐ No Medications

Medication	Dose / Frequency

Completed forms: email to office@bayareapod.com • or bring a printed copy to your appointment

Allergies

☐ No known allergies

Allergy (medication, food, environment)	Reaction

Medical History

Check any conditions that apply: ☐ None of the below

- ☐ AIDS / HIV
- ☐ Anemia / Sickle cell
- ☐ Anxiety / Depression
- ☐ Arthritis (RA / inflammatory)
- ☐ Asthma
- ☐ Bleeding / Clotting disorder
- ☐ Cancer
- ☐ Circulatory disorder
- ☐ CHF (heart failure)
- ☐ Diabetes (Type I / II)
- ☐ GERD / Heartburn
- ☐ GI ulcers
- ☐ Gout
- ☐ Hearing impaired
- ☐ Heart disease
- ☐ Heart attack / MI
- ☐ Hepatitis / Liver disease
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Leg cramps
- ☐ Parkinson’s disease
- ☐ Seizures
- ☐ Spinal stenosis
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Vision impaired
- ☐ Other (below)

If you checked Cancer, Heart attack, or Other — please specify (with approx. dates)

Surgical History

— No prior surgeries or hospitalizations

Surgery / Hospitalization	Year

Family History

Cancer — relative?

Circulatory disorder — relative?

Diabetes (I / II) — relative?

Stroke — relative?

Heart disease — relative?

Other — relative?

Social History

Living situation: — House — Apartment — Other:

Whom do you live with?

Do you drink alcohol? — No — Yes

Drinks per day

Do you smoke? — Never — Former — Current

If former or current — years smoked

Packs per day

Recreational drug use? — No — Yes

Frequency

Any chance you could be pregnant? — No — Yes — Unsure

Last menstrual period

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