South Coast Foot and Ankle Associates

Steve M. Eng, DPM **Benedict Ching, DPM**

Date_____ Home Phone _____Email _____

PATIENT INFORMATION

Name_____ Soc. Sec. # _____

Last Name First Name Initial

Address _____

City _____ State _____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate _____ Marital Status ☐ Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last Name First Name Initial

Relation to Patient _____ Birthdate_____ Soc. Sec. #_____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance ☐Yes ☐No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

Name of Insurance Company(ies)

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

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MEDICAL HISTORY

My foot problem is: _____how long?_____

_____

Prior or self-treatment for this problem: _____

_____

MEDICAL HISTORY Circle any condition YOU currently have or have had:			
Anemia	Ear/hearing problem	HIV (AIDS)	Nerve Pain
Asthma	Epilepsy	Kidney/Urine problems	Phlebitis
Arthritis	Fever	Leg Cramps	Poor Vision/Eye problems
Allergies (seasonal)	Gout	Liver problem	Sickle Cell Anemia
Artificial Joints	Heart problems	Low Back problems	Stomach Ulcers/ problems
Bleeder	Heart Valve Implant	Mental/Emotional problems	Stroke
Chest pains	Hepatitis	Muscle Pain	Tuberculosis
Cancer	High Blood Pressure	Neurological/Muscular problems	Unequal Leg Length
Diabetes YES NO Insulin? YES NO			Varicose Veins
If DIABETIC, doctor treating diabetes: *Dr. Name*_____ *Phone #*_____ *Last date seen*_____			

MEDICATIONS List any prescriptions, over-the-counter, and vitamins	

ALLERGIES List any allergies (ex: penicillin, tape, etc..)	

ADDITIONAL HISTORY		
Do you smoke? Yes No	If yes, amount:	List any surgeries/hospitalization in last 5 years
Do you drink alcohol? Yes No	If yes, amount:	
What is your Height:_____ Weight:_____ Shoe size:_____		
Name of Family Doctor:		
Dr. phone number:	Last date seen:	

Circle YES or NO to report your **FAMILY HISTORY** (blood relatives)

		RELATIVE:			**RELATIVE:**
Diabetes	YES NO		Flat Feet	YES NO	
Cancer	YES NO		Tuberculosis	YES NO	
Bleeder	YES NO		High Blood Pressure	YES NO	
Hepatitis	YES NO		HIV (AIDS)	YES NO	
Bunions	YES NO		Heart Problem/Stroke	YES NO	
Hammertoes	YES NO		Circulation Problem Leg/Feet	YES NO	

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____

Please Print above Signature