Stockdale Podiatry Group, Inc.

PATIENT MEDICAL HISTORY

GENERAL DATA

Patient's Name: _____ Age: _____

Race: _____ Sex: _____

PAST MEDICAL HISTORY

Last Physical Exam: _____

Family Doctor: _____

Hospitalizations: _____

_____

Surgeries: _____

_____

_____

Past & Present Drugs: _____

_____

_____

Allergies: _____

_____

Bleeding Tendencies: _____

Stomach Ulcers: _____

Heart Problems: _____

Rheumatic Fever: _____

Heart Valve Problems: _____

High Blood Pressure: _____

Lung Problems: _____

Liver Problems: _____

Kidney Problems: _____

Diabetes: _____

Blood Clots in Legs: _____

Joint Implants: _____

Smoke: _____ Amount: _____

Alcohol: _____

Other Medical Illnesses: _____

_____

Information Taken by: _____

Date: _____

CHIEF COMPLAINT

_____

_____

_____

_____

_____

When: _____

Type of Pain: _____

_____

Previous Treatment: _____

_____

Job Related: _____

Who referred you to our office?

_____

How did you first hear of us?

_____

Why did you choose this office?

_____

Reviewed by Dr. (Initials) _____

Stockdale Podiatry Group, Inc.

MEDICINE AND SURGERY OF THE FOOT AND ANKLE

3857 Stockdale Hwy.
Bakersfield, California 93309-2187
(661) 832-1666
Fax: (661) 832-7145

REGISTRATION FORM

PATIENT'S NAME_____

ADDRESS_____ CITY _____ STATE _____

ZIP_____ PHONE ( )_____-_____ SEX____ DATE OF BIRTH ___/___/___

MARITAL STATUS (CIRCLE ONE) M S D O

SOCIAL SECURITY # _____-_____-_____ DRIVERS LICENSE # _____

WHO REFERRED YOU TO OUR OFFICE ? _____

EMPLOYER_____ OCCUPATION _____

BUSINESS ADDRESS_____ ZIP_____ PHONE ( )_____-_____

SPOUSE'S NAME _____ DATE OF BIRTH ___/___/_____

EMPLOYER _____OCCUPATION _____

BUSINESS ADDRESS_____ZIP_____ PHONE ( )_____-_____

SOCIAL SECURITY # _____-_____-_____ DRIVERS LICENSE #_____

IN CASE OF EMERGENCY, CONTACT _____ RELATION_____

ADDRESS_____ZIP_____ PHONE ( )_____-_____

PLEASE PRESENT RECEPTIONIST WITH INSURANCE CARDS AND/OR CLAIM FORMS.

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO STOCKDALE PODIATRY GROUP, INC.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

PATIENT'S SIGNATURE _____ DATE_____

Stockdale Podiatry Group, Inc.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

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OFFICE POLICY

WELCOME TO OUR OFFICE

We find that communication with our patients regarding our financial policy assists us in providing the best of service to you. We therefore have taken the time to answer some of the most commonly asked questions.

PAYMENT AT THE TIME OF INITIAL VISIT

Payment is required at the time of the initial visit. Once benefits have been confirmed with your insurance company, we will collect any outstanding deductible, percentage, or co-payment amounts. Any financial arrangements must be made prior to treatment.

LAB FEES

Most insurance companies will pay for laboratory services. If it is necessary for us to order laboratory tests, you will be billed directly by them and responsible for payment of that bill.

REGARDING APPOINTMENTS

If you are unable to keep an appointment you have scheduled, we need at least 24 hours notice to allow another patient to use the time that has been set aside for your visit.

REGARDING INSURANCE

As a courtesy to our patients, we will bill your insurance company for you and withhold action for 6 weeks. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. Please advise us immediately if you are insured.

After receiving payments from your insurance company, we will bill you for any co-insurance, remaining deductible, or balance due on your account. If no payment is made within 60 days, a $5.00 billing charge will be added to your account on each monthly statement.

NOTE

Our office charge for returned checks is $25.00

PLEASE TURN OVER

SPECIAL NEEDS
Special needs are understood by us. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please bring the matter up as soon as possible.

COUPONS/COMPLEMENTARY EXAMS
Any coupons or complementary exams must be given to the receptionist **prior** to being treated.

WE ARE HERE TO HELP
Thank you for taking the time to read this policy statement, we hope that it answers any questions you have. If you have more to ask, please feel free to do so.

If you have any complications with your surgery or treatment, we ask you contact our office immediately for an appointment.

FINANCIAL POLICY REGARDING REFUNDS
It is our company's policy to issue refunds on credit balances that total $20.00 or more, after 90 days of the last payment received. Credit balances less than $20.00 may be applied towards future medical care services. However, for accounting purposes, we may adjust your balance to zero after six months of having a credit balance of less than $20.00. This adjustment can be reapplied towards any medical services in the future.

As patient or legal guardian of a minor patient, I agree to pay all services rendered in accordance with the terms and conditions set forth in the Financial Policy of this office.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my Insurance Company to pay directly to Stockdale Podiatry, the amount due me for Medical Benefits under this claim.

DATE_____ _____
SIGNATURE