Orange County Wound Care Center

New Patient Forms

Patient Name: _____ Date of Birth: _____ Sex: Male / Female

Email: _____ Preferred Contact: Text / Email / Phone (Circle One)

Address: _____ City:_____ State:_____Zip: _____
Mailing Address if Different from Above:
_____

Home Phone Number: _____Cell Number: _____

Driver's License #_____Exp: _____ Social Security #: _____
Patient's Occupation _____ Employer: _____

Work Number:_____ May We Call You at Work: YES / NO

Pharmacy Name: _____ Phone #: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance ID #: _____ Group #: _____

Relationship of Patient to Insured: Self Spouse Child (Circle One)

Are You Covered By Another Insurance: Yes or No (Circle One)

Secondary Insurance: _____ Insurance ID #: _____ Group #: _____

IN CASE OF EMERGENCY:

Primary Contact: _____ Phone #: _____ Relationship: _____

I engage Doctor_____ to render medical care and service to: (Circle One) Myself My Child My legal charge

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

A photocopy of this form shall be considered as effective and valid as the original

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We understand that medical information about you and your health is personal. As custodians of the information in your medical records, we are committed to protecting the privacy of your information as required by law professional accreditation standards and our internal policies and procedures.

A copy of your Notice of Privacy Practice will be kept in the chart. The notice explains your rights, our legal duties and our privacy practices. It also describes how much medical information about you may be used and disclosed and how you can get access to this information.

For your convenience the following is a summary of the information discussed in the notice

- Our Pledge
- Your personal Information
- Our Privacy Practices
- Your written permission
- Other Restrictions
- Changes
- Questions or complaints

We may use your information for:

- Treatment
- Health information exchanges
- Payment
- Health Care Operations
- Notifications
- Marketing Research
- Special circumstances & the law

Please understand that is summary is not our Notice of Privacy Policies, nor is it a substitute for the notice. We ask that your sign and return this cover letter to us for our records.

Printed Name _____ Signature _____ Date _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Foot and Ankle Specialist

16405 Sand Canyon Ave., Suite 270

Irvine, CA 92618

OR, if my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Foot and Ankle Specialist

16405 Sand Canyon Ave., Suite 270

Irvine, CA 92618

For all professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee. I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

I also authorize the release of any information pertinent to my account to any insurance company, adjuster, or attorney involved in this case. I further authorize the doctor to complain to the insurance commissioner or Department of Corporations on my behalf for any reason regarding my insurance

A photocopy of this Assignment shall be considered as effective and valid as the original.

Printed Name _____ Signature _____ Date _____

Financial Policy

We do require payment of any uncovered portion, such as Deductibles, Co-payment, Or Co-Insurance to be paid at the time of Service

To All Anthem Blue Cross Covered CA patients, our office is not in-network with this plan. Patients are responsible to contact their plans for clarification of benefits prior to services being rendered.

As our patient, you are responsible for all the authorizations/referrals needed to seek treatment in this office.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services being rendered.

For most elective surgical procedures (office, our-patient hospital and ambulatory surgical center) we will require you to pay only co-pay/co-insurance/deductible prior to surgery. We will bill your health plan and any additional balance due is your responsibility.

Past due accounts are subject to collection proceedings. All costs incurred, including, but not limited to collection fees, attorney fee, and court fees shall be your responsibility in addition to the balance due this office.

There is a service fee for all returned checks. Your insurance company does not cover this fee.

There are fees associated with copying medical records and x-ray films. You will be informed of current charges at the time of such request. Your insurance company does not cover this fee.

There are fees for any documents that are required to be completed by our office (State disability forms, Insurance forms, etc..).

If an appointment is cancelled with less than 24hr notice to our office, or if a scheduled appointment is missed/forgotten, there will be a fee of $50.00, or the equivalent of your office co-pay. This fee will only be waived in case of an emergency or illness.

Printed Name _____ Signature _____ Date _____

MEDICAL HISTORY

****

Name: _____ Date of Birth: _____/_____/_____

Please describe your present problem(s): _____

_____

How long have you had this problem? _____Days, _____Weeks, _____Months, _____Years

Have you had previous treatment for this problem? _____Yes _____No

If yes, by whom and when: _____

Family Physician: _____Last Visit Date: ___/_____/_____

Please check *Yes* or *No* to indicate if you have any of the following:											
	Y	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
Aids/HIV			Circulatory problems			Hepatitis			Radiation treatment		
Allergies to anesthetics			Depression			High blood pressure			Respiratory disease		
Anemia			Diabetes			Jaundice			Rheumatic fever		
Angina			Dialysis			Kidney problems			Rheumatoid arthritis		
Arthritis			Ear problems			Liver disease			Sinus problems		
Artificial heart valves			Epilepsy			Low blood pressure			Skin cancer		
Artificial joints			Eye problems			Nervous problems			Stroke		
Asthma			Fainting			Neuropathy			Swollen neck glands		
Back problems			Glaucoma			Osteoporosis			Thyroid problems		
Bleeding disorders			Gout			Phlebitis			Tuberculosis		
Cancer, _____			Heart attack			Pneumonia			Ulcers		
Cataracts			Heart disease			Prostate problems			Varicose veins		
Chemical dependency			Heart surgery			Psoriasis			Venereal disease		
Chronic diarrhea			Hemophilia			Psychiatric care			Other, _____		

Previous Surgeries: *(Please list **all** prior surgeries and dates.)*

_____

_____

Previous Hospitalizations: *(Please list reason/dates for hospitalizations other than for above surgeries.)*

_____

_____

Medications: *(Please list **all** current medications including over-the-counter medications and oral contraceptives.)* _____

_____

_____

Family Medical History: *(Please list any significant family history.)*

_____

_____

Allergies: *(Please circle any allergies you have.)* _____*No known drug allergies*

Adhesive tape Aspirin Codeine Demerol Iodine Local Anesthetics

Penicillin Sulfa Other antibiotics_____ Other Medication_____

****

Smoking History: ( ) Never smoked ( ) Past smoker ( ) Current smoker, #/day_____

Alcohol Use: ( ) No ( ) Yes, how often/how many_____

Review of Body Systems

Please check if you have any of the following.

Eyes: ☐ Blurred vision ☐ Blindness

Musculoskeletal: ☐ Pain ☐ Weakness ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Foot/Leg cramps

Integument: ☐ Rashes ☐ Dry skin ☐ Itching

Respiratory: ☐ Shortness of breath ☐ Wheezing ☐ Cough

Cardiovascular: ☐ Chest pain ☐ Swelling ankles/feet

Neurologic: ☐ Seizures ☐ Numbness ☐ Tingling ☐ Dizziness

Constitutional: ☐ Weight gain ☐ Weight loss ☐ Fever ☐ Fatigue

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Jaundice

Genitourinary: ☐ Frequent urination ☐ Burning urination ☐ Discharge

Hematologic: ☐ Bleeding ☐ Excessive bruising ☐ Using blood thinners

Comments: _____

_____

_____

_____

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.

_____ _____/_____/_____

Signature of patient or legal guardian *Date*