Cabrillo Podiatry Group
Kristine Kelly Nemes, D.P.M.
669 Crespi Drive, Suite B
Pacifica, CA 94044

Date: _____

Patient Information:

Name: _____ **Gender:** Male / Female

Social Security #: _____ **Date of Birth:** _____ **Age:** _____

Marital Status: Single Married Divorced Widow Domestic Partnership

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work:** _____ **Cell Phone:** _____

Which phone is okay to leave detailed messages on: Home / Work / Cell / None

Email: _____

Preferred method of communication: Email / Phone

Occupation: _____

Employer: _____

Employer Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact: _____ **Phone #:** _____ **Relationship:** _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Medical Insurance Information:

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

Whom may we thank for referring you? _____

Primary Care Physician: _____

Address: _____

Phone Number: _____

Have you ever been to a Podiatrist before? Yes / No **Last Visit:** _____

Physician's Name: _____

Patient Name: _____

GENERAL HEALTH HISTORY

1. What are your present foot/ankle problems? _____
2. How long have you had these problems? _____
3. Have you tried any treatment? Please list. _____
4. Do you have/ or have you ever had any of the following? Please check yes or no.

	Yes	No	Family		Yes	No	Family
Anemia (low blood count)	___	___	___	High Blood Pressure	___	___	___
Arthritis	___	___	___	HIV/AIDS	___	___	___
Back Problems/Sciatica	___	___	___	Kidney Disease	___	___	___
Blood Disease	___	___	___	Liver Trouble	___	___	___
Blood Thinners	___	___	___	Low Blood Pressure	___	___	___
Calf pain	___	___	___	Lower Back Pain	___	___	___
Cancer	___	___	___	Mitral Valve Prolapse	___	___	___
Chemical Dependency	___	___	___	MRSA Infection	___	___	___
Circulatory Problems	___	___	___	Numbness (foot)	___	___	___
Congenital Heart Disease	___	___	___	Pacemaker	___	___	___
Diabetes	___	___	___	Pneumonia	___	___	___
Depression	___	___	___	Prostate Problems	___	___	___
Emphysema	___	___	___	Respiratory Disease	___	___	___
Epilepsy	___	___	___	Rheumatic Fever	___	___	___
Foot Ulcerations	___	___	___	Sleep Apnea	___	___	___
Gout	___	___	___	Shortness of Breath	___	___	___
Heart Murmur	___	___	___	Stroke	___	___	___
Heart Disease	___	___	___	Thyroid Problems	___	___	___
Hepatitis – Type___	___	___	___	Varicose Veins	___	___	___
DVT (blood clot)	___	___	___				

5. Please list any operations you have had: _____

   _____

6. Please list all prescription and non-prescription medications you are currently taking with dosage:

   _____

   _____

7. Do you have any allergies? If yes, please list the following:

   _____

   _____

8. Height _____ Weight _____ Shoe Size _____
9. Race: African / Asian / Caucasian / Hispanic / Native American / Native Hawaiian or Pacific Islander / Other
10. Primary Language: English / Other: _____
11. Social History: Do you smoke? Yes / No / Past How many packs a day? _____
12. If Diabetic, last A1C: _____ 11. Last flu shot: This year / Last year / Neither

For office use only: Blood Pressure: _____ Heart Rate: _____

_____

Patient Signature Date

Cabrillo Podiatry Group
Kristine Kelly Nemes, D.P.M.
669 Crespi Drive, Suite B
Pacifica, CA 94044

INSURANCE ASSIGNMENT AND RELEASE:

I certify that I have insurance with _____
(Name of Insurance Company(ies)

And assign directly to Dr. Kristine Nemes all insurance benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether 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 above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient/Guardian _____ **Please Print** _____

Date _____ **Relationship to Patient** _____

MEDICARE/HPSM AUTHORIZATION:

I request that payment of authorized Medicare benefits, and if applicable, HPSM benefits, be made on my behalf to Dr. Kristine Nemes for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and HPSM services, my HPSM insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient/Guardian _____ **Please Print** _____

Date _____ **Relationship to Patient** _____

TREATMENT OF CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform treatment of my concerns upon a thorough discussion with the doctor.

Signature of Patient, Guardian, or Personal Representative _____ **Date** _____

Please print name of Patient, Guardian or Personal Representative _____ **Relationship to Patient** _____

Cabrillo Podiatry Group's Office Policies

1. If you need to reschedule, call within 24 HOURS of scheduled appointment in order to avoid a $25 fee.

2. If you are late to your appointment by 15 minutes or more, we have the right to reschedule your appointment. Please call the office ahead of time if you will be late to your appointment.

3. All insurance **CO-PAYS** and applicable **DEDUCTIBLES** are due at the time of the visit.

4. **IT IS THE PATIENT'S RESPONSIBILITY** to update any changes in insurance or contact information with our staff in order to avoid an out of pocket expense.

5. **IT IS THE PATIENT'S RESPONSIBILITY** to know what is covered under their insurance plan.

6. If your insurance policy requires a referral to see a specialist, please have the referral at the time of the visit.

7. Should you receive payment from the insurance company for the doctor, timely reimbursement for your care is imperative.

8. If you are diabetic, please be sure to provide your primary care physician's name and contact information.

I HAVE ACKNOWLEDGED AND AGREE TO FOLLOW THE POLICIES OF THIS OFFICE.

Print:_____ **Signature:**_____

Date:_____