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

**Date: _____** **Driver's License/ID Checked: ☐**

**Patient Information:**
*Needed for Billing Purposes*

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

**Title:** Dr./Mr./Mrs./Ms./Miss/Other:_____ **Pronouns**: He/Him or She/Her or Other: _____

**Preferred Name:** _____

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

**Marital Status**: Never Married Married Separated Divorced Widowed 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:** _____

**Are you: ☐ a student? ☐Employed? ☐Stay-at-home parent/spouse? ☐On disability? ☐Retired?**

**Grade in School/Occupation/Former Occupation:** _____

**School/Employer:** _____

**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/Pediatrician:**_____

**City:** _____ **Phone Number:** _____

**If Applicable:**

**Cardiologist:** _____ **Endocrinologist:** _____

**Nephrologist:** _____ **Rheumatologist:** _____

**Vascular Surgeon:** _____ **Orthopedic Surgeon:** _____

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

**Physician's Name:** _____

**Patient Name: _____**

## GENERAL HEALTH HISTORY

### Current Issue

1. **What are your present foot/ankle problems? _____**
2. **How long have you had these problems? _____**
3. **Have you tried any treatment? Please list. _____**

### Medical Issues

**Please check any that you have/have had:**

- ☐ **Anemia**
- ☐ **Aneurysm**
- ☐ **Anxiety**
- ☐ **Asthma**
- ☐ **Atrial Fibrillation**
- ☐ **Autism/on the spectrum**
- ☐ **Bipolar**
- ☐ **Blindness**
- ☐ **Cataracts**
- ☐ **Cirrhosis**
- ☐ **Congestive Heart Failure**
- ☐ **COPD**
- ☐ **Dentures**
- ☐ **Depression**
- ☐ **Dialysis**
- ☐ **Type 1 Diabetes**
- ☐ **Type 2 Diabetes**
- ☐ **Down Syndrome**
- ☐ **DVT (Blood Clot)**
- ☐ **Eczema**
- ☐ **Emphysema**
- ☐ **Epilepsy**
- ☐ **Foot/Leg Ulcers/Wounds**
- ☐ **GERD (gastric reflux)**
- ☐ **Glaucoma**
- ☐ **Gout**
- ☐ **Head Trauma**
- ☐ **Hearing Loss**
- ☐ **Complete Hearing Loss**
- ☐ **Heart Attack (MI)**
- ☐ **Heartburn**
- ☐ **Heart Murmur**
- ☐ **Hepatitis**
- ☐ **Hernia**
- ☐ **High Cholesterol**
- ☐ **HIV/AIDS**
- ☐ **Hypertension**
- ☐ **Hypothyroidism**
- ☐ **Kidney Disease/Failure**
- ☐ **Mental Delay**
- ☐ **Migraines**
- ☐ **Non-verbal**
- ☐ **Psoriasis**
- ☐ **Pulmonary Embolism**
- ☐ **Raynoud's/Chilblains**
- ☐ **Seizures**
- ☐ **Sleep Apnea**
- ☐ **Stroke (CVA)**
- ☐ **TIA (Transient Stroke)**
- ☐ **Wears Glasses/Contacts**

- ☐ **Other heart disease: _____**
- ☐ **Cancer: (Current/Previous): _____**
- ☐ **Skin Cancer (Melanoma, Basal Cell, Squamous Cell)**
- ☐ **Blood thinners (Warfarin, Coumadin, Heparin, Xarelto, Plavix, Eliquis, Pradaxa)**
- ☐ **Rheumatologic Issues: RA, Lupus, psoriatic arthritis, Sjogren's, Other: _____**
- ☐ **Implants:** (Circle): **Toe/Ankle/Knee/Hip/Pacemaker/Defibrillator/Other**: **_____**
- ☐ **Issues during your pregnancy/birth? _____**

4. **Please list any surgeries/operations you have had**: **_____**
   **_____**
5. **Please list all prescription and non-prescription medications you are currently taking with dosage:**
   **_____**
   **_____**
6. **Do you have any allergies to medications? If yes, please list with your reaction (hives, anaphylaxis, etc):**
   **_____**

**Patient Name: _____**

**FAMILY HISTORY**

**Mother:** ☐Alive ☐Deceased at age: ____ **Issues:** ☐Diabetes ☐HTN ☐Heart Disease ☐Cancer ☐Other_____
**Father:** ☐Alive ☐Deceased at age: ____ **Issues:** ☐Diabetes ☐HTN ☐Heart Disease ☐Cancer ☐Other_____
**# Brothers: ____ If Deceased , what age: _____ Medical Issues**_____
**# Sisters: ____ If Deceased , what age: _____ Medical Issues**_____
**# Sons: ____ If Deceased , what age: _____ Medical Issues**_____
**# Daughters: ____ If Deceased , what age: _____ Medical Issues**_____
**Other Relative: _____ If Deceased , what age: ____ Medical Issues**_____
**Other Relative: _____ If Deceased , what age: ____ Medical Issues**_____
**Other Relative: _____ If Deceased , what age: ____ Medical Issues**_____
**Other Relative: _____ If Deceased , what age: ____ Medical Issues**_____

7. **Race:** ☐American Indian ☐Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian ☐Pacific Islander ☐White ☐Other ☐Unknown
8. **Hispanic/Latino:** ☐Yes ☐No
9. **Primary Language:** English / Other: _____

**SOCIAL HISTORY**

10. **Do you smoke?** ☐Every day ☐Some days ☐Former ☐No
11. **Do you drink alcohol?** ☐Daily ☐Occasionally ☐Rarely ☐ No ☐History of alcoholism
12. **Do you smoke marijuana?** ☐Daily ☐Occasionally ☐Rarely ☐ No
13. **Do you exercise?** ☐No ☐Occasionally. ☐3-5 times a week ☐5+ times a week. **TYPE:** _____
14. **If Diabetic: years since diagnosis?** _____ **Typical finger stick blood glucose**: _____
    **Last A1C:** _____ **When?** _____ **History of foot/leg ulcers?** _____
    **Last Visit with PCP/Endocrinologist:** _____ **Name of Doctor Seen**: _____
15. **Last flu shot:** This year / Last year / Neither
16. **Height** _____ **Weight** _____ **Shoe Size** _____

**Patient Signature** **Date**

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## 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 benefits, 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.

_____ _____
**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**

## CONSENT FOR TREATMENT

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 5 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,** if known, are due at the time of the visit.

4. If you are billed for a **CO-PAY, CO-INSURANCE, and/or DEDUCTIBLE**, you have 30 days from when the bill is mailed to you to pay it. **After 60 days, a $15 late fee will be added to your bill.** 120 days after the first bill is sent, unpaid accounts **will be sent to collections and an addition $15 late fee will be added to the account** (for a total of $30 in late fees).

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

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

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

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

9. 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:_____**