Thomas Rambacher
DPM, FACFAS, FAPWCA

Michael Bastani
DPM, DABPM

PODIATRY HOTLINE
FOOT & ANKLE

26302 La Paz Rd, Suite #101
Mission Viejo, CA 92691

Office: (949) 916-0077
Live Chat: (949) 203-1803
Fax: (949) 916-7888

Patient Information Form

Please Print

Today's Date: _____

☐ Male ☐ Female

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____

Parent or Guardian (If patient is a minor): _____

Home Address: _____ APT: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail (Required): _____

Social Sec.#: _____

Employer: _____

Primary Language: _____ Ethnicity: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

Height: ____ Ft: ____ Inch **Weight**: _____ lb. **Shoe Size:** _____

Primary Care Physician Name: _____

Date of last visit: _____

Address: _____

Phone: _____

Pharmacy Name: _____ Phone: _____

Reason for This Visit: (please print)

_____

_____

Please indicate which of the following best describes your current foot/ankle problem:

☐Heel Pain ☐Bunion ☐Corn & Callus ☐Thick nails ☐Ingrown toenail

☐Numbness ☐Muscle cramp ☐Athlete's foot ☐Ankle Pain ☐Flat feet ☐Gout

☐Wart ☐Swelling/ edema ☐Sprain ☐Trauma ☐Sports related injury ☐Arthritis

☐Soft tissue mass ☐Diabetic foot care Other:_____

Any previous lower extremity injury and/or surgery: (please print)

_____

_____

Have you ever been to a podiatrist before? ☐ Yes ☐ No

Name: _____

Date of last visit: _____

Have you ever used orthotics? ☐ Yes ☐ No

Which of the following activities require you to stand on your feet daily?

☐ Sports ☐ Walking ☐ Jogging ☐ Running ☐ Work ☐ Exercise

How many hours per day are you on your feet? _____

Please list any other physical activities in which you participate: (please print)

_____

_____

Past Medical History

List of Medical Problems: (please print)

_____

_____

Have you had or ever been treated for the following?

Yes | No		Yes | No		Yes | No	
☐	☐ Heart attack	☐	☐ Ankle/ knee injury	☐	☐ Pneumonia
☐	☐ Gout	☐	☐ Arthritis	☐	☐ Varicose veins
☐	☐ Blood disease	☐	☐ Poor circulation	☐	☐ Heart disease
☐	☐ Blood clots	☐	☐ Back pain	☐	☐ Kidney disease
☐	☐ High blood pressure	☐	☐ Foot Injury	☐	☐ Stomach ulcers
☐	☐ Diabetes	☐	☐ Bleeding Tendency	☐	☐ Thyroid disorder
☐	☐ Alcoholism	☐	☐ Asthma	☐	☐ Peripheral neuropathy
☐	☐ Anemia	☐	☐ Cancer	☐	☐ HIV+
☐	☐ Dizziness	☐	☐ Hepatitis	☐	☐ Stroke

List of Current Medications: (please print)

_____

_____

_____

Allergies/ Reactions:

☐ None ☐ Penicillin ☐ Codeine ☐ Cortisone ☐ Anesthetics ☐ Vicodin

☐ Aspirin ☐ Demerol ☐ Latex ☐ Iodine ☐ Sulfa drugs

☐ Other: _____ Please describe the effect(s): _____

Past Surgical History: (please print)

_____

_____

Social History:

Do you currently smoke? ☐ Yes ☐ No ☐ Occasionally ☐ Never

If yes, how long have you been smoking? _____

How many cigarettes per day? _____

How often do you consume alcoholic beverages? ☐ Daily ☐ Socially ☐ Do not drink

Is there any pertinent family history our physicians should know about you? **(please print)**

_____

_____

Whom may we thank for referring you?

☐ Doctor _____

Phone: _____

Address: _____

☐ Patient/Friend (Name) _____
☐ Insurance Directory
☐ Internet Search (please specify): ☐ Google ☐ Yahoo ☐ Social media:
☐ Other:_____

Permission to Treat

I, _____ hereby give permission to physicians at Podiatry Hotline Foot & Ankle to examine, to photograph, to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle problem.

Signature (Patient or Guardian): _____ Date: _____

Financial Policy / Assignment of Benefits & Payments

It is always good policy to understand and agree with the financial policy of an office. We appreciate having you as our patient and strive to provide you with the best care possible. Misunderstandings regarding insurance coverage and financial policy make it uncomfortable for everyone. If you ever have any questions or wish to discuss your account with us, please do not hesitate. Your signature indicates your understanding and agreement to the following policies:

Assignment of Benefits and Payments

I authorize payment for services rendered to me or my dependents to be paid directly to the physicians at Podiatry Hotline Foot & Ankle from my insurance company, my attorney, or any other party who may become obligated to pay the physicians at Podiatry Hotline Foot & Ankle any sums. I further authorize the endorsement of my name to any draft containing my name to which the physicians at Podiatry Hotline Foot & Ankle is legally entitled.

Pre- Authorization by your insurance company:

If my insurance plan requires a pre-authorization from my primary physician, **I, as the insured party, am responsible for obtaining pre-authorization prior to my appointment.** If this has not been done, I will be asked to pay for my visit or will be asked to reschedule my appointment until this information is obtained. Of course, I have a right to pay for medical services that are not determined to be coverable by my insurance company.

In-Network:

I realize I am responsible for determining if any of physicians at Podiatry Hotline Foot & Ankle is in-network with my insurance plan. If the physician is not in-network, I am responsible for out of network benefits and/or uncovered fees.

Referrals:

If my insurance plan is an HMO and/or requires a referral to see any of the physicians at Podiatry Hotline Foot & Ankle, I realize I am responsible in obtaining the referral from my primary care physician. If service is given without referral, I realize I am responsible for the fee.

Financial Responsibility:

Commercial insurance is filed as a courtesy to the patient, and managed care insurance is filed with the contracted carrier. I understand that I will be held financially responsible for any balances incurred in this office as well as for any charges that are not paid by my insurance company, including, but not limited to, co-pays, deductibles, co-insurance and services or charges not paid by insurance for any reason, after consideration of contractual adjustments.

Outstanding Balances:

In the event that my account goes into default and your office turns it over to an outside collection agency/attorney for collection, it is accepted and agreed that thirty percent (30%) of the principal amount of the balance is due will be added as collection/attorney fees. It is also agreed and accepted that in the event that a lawsuit is filed, I will be liable for any and all court costs expended whether judgement has been entered or not.

Non-Sufficient Funds or Closed Accounts:

There will be a **$30.00 service charge.** I realize that your bank charges you for my NSF check and my bank will charge you for the check as well. I will let you know if I need to make payments over time. I understand that your office will definitely make arrangements with me.

Missed Appointment Charges:

Missed appointments mean that not only were my feet not treated but someone else could have been seen and helped. If I fail to cancel an appointment at least 24 hours prior to my appointment, or if I miss the appointment completely**, I understand there will be a $25.00 charge.** I understand the payment for this charge will be collected at the time of my next appointment, unless I pay the amount beforehand.

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the treating physician at Podiatry Hotline Foot & Ankle for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductibles are based upon the charge determination of the Medicare carrier.

Authorization To Release Information:

I authorize Podiatry Hotline Foot & Ankle to release any information regarding the medical history and treatment including disability related information to any third-party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

Signature: _____ Date: _____