CONFIDENTIAL

Leonard Greenwald DPM

750 North Capitol Avenue Suite B-3 San Jose, CA 95133
Phone: (408) 926-5855 Fax: (408) 926-2544

PATIENT INFORMATION

Name: _____
Last Name First Name Middle Initial

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

Address: _____

City: _____ State: ____ Zip Code: _____

Preferred Phone Number: _____ Secondary Phone Number: _____

Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Both

Sex: ☐M ☐ F Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed

EMERGENCY CONTACT

Name: _____

Phone Number: _____ Relationship to Patient: _____

Medical & Financial Information can be discussed with:

☐Patient Only ☐ Family Member/Friend Name: _____

Relationship to Patient: _____ Phone Number: _____

RESPONSIBLE PARTY IF PATIENT IS UNDER AGE 18

Name: _____ Date of Birth: _____

Phone Number: _____ Relationship to Patient: _____

Sex: ☐ M ☐ F Social Security #: _____

WELCOME TO OUR PRACTICE!! WHOM MAY WE THANK FOR RECOMMENDING US:

Referral Name: _____

☐Yelp ☐ Google ☐ Primary Care Doctor ☐ Insurance ☐ Other:_____

Reason for your visit

Right: ☐Foot ☐ Ankle Left: ☐Foot ☐ Ankle Both Left & Right: ☐Foot ☐Ankle

Brief Explanation: How and when did this discomfort begin: _____

_____

Describe Pain/Discomfort:

☐Burning ☐Numbness ☐Sharp ☐Other: _____

What makes the pain/discomfort better: _____

Have you had physical trauma: ☐NO ☐ YES_____

Are you currently pregnant: ☐NO ☐ YES

Occupation: _____ Is your problem work related: ☐NO ☐ YES

Medical History: ☐NONE

☐Anemia	☐High Blood Pressure	☐Osteoarthritis
☐Bleeding Disorders	☐High Cholesterol	☐Other Arthritis
☐Cancer: _____	☐HIV ☐ AIDS	☐Prostrate Disorders
☐Diabetes	☐Kidney Disease	☐Rheumatic Fever
☐Epilepsy	☐Lung/Respiratory Disorders	☐Stroke
☐Gout	☐Mitral Valve Prolapse	☐Thyroid Disorders
☐Heart Failure	☐Nerve Disorders	☐Other
☐Hepatitis ____	☐Neurological Disorders	

Prescribed Medication List: ☐NONE _____

_____

Allergies (Describe Reaction: Mild, Moderate, Severe): ☐NONE

☐Penicillin_____	☐Aspirin_____	☐Narcotic Agent/Codeine____
☐Anesthesia_____	☐Shellfish_____	☐Sulfa Drugs_____
☐Nickel/Metal_____	☐Radiographic Contrast Dye_____	☐Other_____

Surgical History (If you had surgery, please provide details: Type & Date/Year):

☐NO ☐ YES_____

Social History:

☐Tobacco Use ☐Alcohol Use ☐Caffeine Use ☐Drug Use (Recreational IV)

☐Exercise Habits_____

Family Health History (List Relationship of family member(s) who have/had these problems:

☐Diabetes_____	☐Cancer_____	☐Rheumatology_____
☐Heart Disease_____	☐Mental Illness_____	☐Other Family History_____
☐Hypertension_____	☐Stroke_____	
☐Kidney Disease_____	☐Bleeding Disorders_____	

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

OFFICE POLICY

Appointments: Thank you for keeping your appointment time and arriving promptly! When you arrive, please notify our team member at the front desk before taking a seat. Please schedule all appointments in advance so that we may serve you expeditiously.

Cancellation Policy: Availability and accessibility is one of our core values. Should you need to cancel or reschedule, please let us know at least 24 hours in advance; if not, please recognize that there will be a $25 cancellation fee. Your cancellation notification allows us to accommodate to our patients' schedules and schedule anyone who may need to be seen urgently in the office or the hospital. Thank you for your understanding.

Patient with Insurance: We will bill your insurance company/medical group for all services rendered; kindly note that you are ultimately responsible for payment for provided services. If payment has not been received within sixty (60) days of billing your insurance company/medical group, we will contact you for assistance. Should your insurance company/medical group deny coverage for any reason, you will be responsible for the full payment within thirty (30) days of your billing statement.

Co-Pay Policy: If your insurance has a co-pay, the co-payment is due at the time of your visit. A co-pay is collected for all office visits, including visits with the doctor or other medical staff members. If you are unable to pay the co-pay, please reach out to us for assistance. Kindly note that for unpaid co-pays, we will mail you a statement which will result in an additional $10 statement fee.

Authorization and Assignment of Benefits: In the Patient Registration Paperwork (Page 4) is a statement regarding release of information and assignment of benefits. This authorizes Leonard Greenwald, D.P.M. to release medical information to your insurance plan/medical group that may be needed to process/pay for your claims. The "assignment of benefits" requests that insurance payments be made directly to Leonard Greenwald, D.P.M. and also acknowledges that you are responsible for payment if the assignment is not honored.

Patients without Insurance: Our fees cannot be determined in advance for our in-office procedures, as they depend on the services rendered. After your consultation, you will be quoted a deposit amount which must be paid at the time of evaluation. Any charge over the deposit amount will be due on the day of your procedure/next visit.

Miscellaneous fees: Our office will gladly copy medical records and complete medical forms such as disability forms, family leave forms, airline cancellation request forms, etc. for our patients. Regardless of the number of hours spent, there will be a flat fee of $25.

Returned Checks: There is a $30 service fee for all returned checks.

Please call our office at (408) 926-5855, should you have any questions or concerns. Our office hours are from 9:00 AM-5:00 PM PST.

I have read, understand and agree to comply with the above policies. I attest that all the information given is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

OUR PROMISE OF PRIVACY AND CONSTENT TO PATIENT RECORDS (HIPAA)

Our office is fully committed to complying with HIPAA Guidelines by:

1. Providing appropriate security for our patient records
2. Protecting the privacy of our patients' medical information
3. Providing patients with proper access to their medical records
4. Appropriately maintaining our patient information and billing processes in compliance with national HIPAA standards

Should you have any questions or concerns about your services or charges, we encourage you to call and ask for our Compliance Officer.

Patient Signature: _____ Date: _____

PATIENT RESPONSIBILITY POLICY

Please provide Leonard Greenwald, D.P.M. with updated and accurate insurance information. If you do not have your insurance card or information, then payment is due at the time of your visit. In order to be compliant with insurance companies, you must pay your co-pay at the time of your visit. While we assist you with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you are required an authorization, and payment of the bill. Your insurance payment should be made to Leonard Greenwald, D.P.M. for all services rendered. Patient authorizes release of information, as necessary to satisfy submitted claims, by the above-named medical office to your insurance.

Patient Signature: _____ Date: _____

MEDICARE "SIGNATURE ON FILE" REQUIREMENTS

I request that payment of authorized Medical benefits be made either to me or on my behalf to Leonard Greenwald, D.P.M. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to be released to the Healthcare Financing Administration and its agents; any information needed to determine these benefits payable to related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____