NORTHERN CALIFORNIA FOOT AND ANKLE CENTER

ROBERT S. SALK, DPM | KIRK A. GROGAN, DPM | MARK S. CO, DPM | JAVERIA HUSSAINI, DPM

Davies Campus - 45 Castro St, Suite 315 San Francisco, CA 94114

Pacific Campus – 2100 Webster St, Suite 209 San Francisco, CA 94115

Last Name: ______________________First Name:_______________________ MI:_____ Pref. 1st Name:_________________

Birth Date ____/____/____ Shoe Size: _______Sex: _________ E-Mail ___________________________@________________

Home Address____ Apt #:________

City: __________________________State _______Zip ________________

Primary Contact Phone Number: (_______)_______-_________ Cell: (______)_______-__________

Marital Status: __Married | __Single | __Domestic Partnership | __Widowed | Other:________________

Occupation: ____Full-Time Student ____Part-Time Student | Employment Status: _____ F-Time _____P-Time
____Self-Employed Other: _________________ Employer Name ________________________________

Emergency Contact Name & Relationship to Pt________________________________ Day Phone (_____)_______-_________
Primary Care Dr. ____ Phone (______)________-__________
Physician Address ____

Under 18 Years- Complete Responsible Party Information
Parent / Responsible Party Name _____________________________________ Relationship to Patient ___________________
Address if Different from Home ____ Day Phone (_____)_______-__________

How did you choose NCFAC for your Podiatric needs? __Physician Referral __ Insurance Website __Other Medical Referral
__Yelp Review__ Family Member/ Friend/Colleague Other: ____

Insurance ID(s) and Mandatory Completion Required From Computer Billing Service (415) 683-3223

Primary Insurance Company ________________________________ PPO | HMO
Are you the Subscriber or Primary Policy Holder on this Insurance? ____Yes | ____ No
Name of Subscriber (Policy Holder) _____________________________________Subscriber Birth Date _____/_____/______
Patient's Relationship to Subscriber_________________ Subscriber's Employer _____________________________________

Secondary Insurance Co_______________________________
Name of Subscriber 2nd Insurance __________________________________ Subscriber Birth Date _____/_____/______
Patient's Relationship to Subscriber_________________ Subscriber's Employer _____________________________________

Is visit related to accident or injury? __Yes __No | If Yes, Date of Injury__________ Type of Injury: __Work __Auto __Other
Place of Injury ________________________ How were you injured? ____

Assignment of Benefits: I hereby assign payment directly to Northern California Foot & Ankle Center, the insurance benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization. I also authorize a photocopy of this assignment as if it were an original copy. If it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay the reasonable attorney's fee and collection expenses. Further, I understand that coinsurance, unsatisfied deductible amounts, etc. are requested at the time of services unless other financial arrangements are made in advance. I understand that if I don't keep my scheduled appointment or if I don't cancel my appointment at least 24 hours in advance, I will be charged a $85.00 missed appointment fee.

Signature: ____ **Date: _________________________**

MEDICAL HISTORY

Name: ____ Today's Date: ______/______/______
Complaint: ____

If you're a Sutter West Bay Network patient and you recently saw a Sutter Affiliated Primary Care Doctor, write your initials here___________ to mark that system is updated and sign the bottom part of the page. Otherwise, please fill out the form.

Please check all applicable medical conditions that apply to you:

- ☐ Arteriosclerosis
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Gout
- ☐ Muscle Spasms
- ☐ Asthma
- ☐ Heart Disease
- ☐ Anemia
- ☐ Hemophilia
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Hepatitis
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Sinus Trouble
- ☐ Chronic Cough
- ☐ High Cholesterol
- ☐ Stroke/Seizures
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ HIV/AIDS
- ☐ Thyroid Problems
- ☐ Emphysema
- ☐ Joint Pain/Stiffness
- ☐ Tuberculosis
- ☐ Fainting
- ☐ Kidney Problems
- ☐ Ulcers
- ☐ Vascular Disease
- ☐ Other: ______________

Social History:
Do you smoke? __Yes __No __Quit
Do you use e-Cigarette/ Vaping? __Yes __No __Quit
Do you drink Alcoholic Beverage? __Yes __No If Yes, How Much per day?__________

Surgical History:
1. _____________________________Year:__________ 2.___________________________Year: __________
3. _____________________________Year:__________ 4.___________________________Year: __________
5. _____________________________Year: __________6.___________________________Year: __________

Medications:
1. ______________
2. ______________
3. ______________
4. ______________
5. ______________
6. ______________
7. ______________
8. ______________
9. ______________
10. ______________
11. ______________
12. ______________
13. ______________
14. ______________
15. ______________

Known Allergies to Medication(s):
1. ______________
2. ______________
3. ______________
4. ______________

Preferred Pharmacy and Address (if known) : ____

Signature: ____ Date: ________________________

Northern California
FOOT & ANKLE CENTER

Reconstructive Surgery of the Foot and Ankle
Sports Medicine and Arthroscopy
Pediatric and Geriatric Foot Care
Diabetic Foot Care

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Cancellation Policy/ No Show Policy

Dear Patients:

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel a scheduled appointment, you may be preventing another patient from getting much needed treatment at the same time slot.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a fee of $85.00; this is not covered by your insurance.

Our phones are open from 8:00AM -12:00 PM and 1:00PM TO-5:00PM, and staff are ready to assist you Monday thru Friday. If you reach us during non-office hours please leave a voicemail.

Thank you for your consideration to the doctors and our office.

Signature: ______________________________________ **Date:** ______________________

CALIFORNIA PACIFIC MEDICAL CENTER

Pacific Campus
2100 Webster Street, Suite 209
San Francisco, CA 94115
Phone: (415) 431-FOOT (3668)
Fax: (415) 703-6248

Davies Campus
45 Castro Street, Suite 315
San Francisco, CA 94114
Phone: 415-565-0200
Fax: 415-565-0296

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Privacy Notice

This page serves to inform you of the privacy practices of Northern California Foot & Ankle center and its representatives. The privacy of your medical information is important to us. We intend to honor your privacy in every way possible. By signing below, you will allow us to disclose your personal health information:

- For treatment of your medical condition
- For help in attaining the maximum benefits allowed by your insurance company
- To any 3rd party representatives also working in the treatment of your medical diagnosis.
- By Superior or Federal Court Subpoena.

We respect your rights in maintaining the utmost in privacy in regards to your individual health information. We will not release any of your health information to non-medical entities without your prior written permission. Northern California Foot & Ankle Center maintains physical and electronic safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets and controlled computer network systems and password accounts. We will only disclose your medical information to your health plan or other health care professionals or facilities for purposes of diagnosis or treatment of your medical condition. If you prefer that we do not disclose any or all of your medical condition(s), please inform us so that we may take any necessary precautions.

NOTICE TO CONSUMERS
Doctors of Podiatric Medicine are licensed and regulated by the Medical Board of California.
(800) 633-2322 |bpm.ca.gov

Signature: ____ **Date:** ________________________

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Virtual Appointments

In order to better serve our patients' medical needs, we are offering options available through a two-way, live telehealth interaction often times referred to as a "virtual appointment."
These visits use audio, video and other e-communication to allow interaction with a physician for the purpose of diagnosis, treatment, patient education and follow-up.

Prior to your virtual appointment, new patients are responsible for submitting all required forms online, and provide insurance information.
Our staff will provide instructions on how to access our TeleMed platform, Doxy.me., and other details relevant to your scheduled virtual appointment.

Virtual appointments are professional services for which the patient, or his or her guardian, must accept full financial responsibility in accordance with the regular rates and terms of Northern California Foot and Ankle Center. This includes financial responsibility for all copays, deductibles, and co-payments that may be required by your health plan. You are encouraged to confirm coverage of virtual visits with your health plan.

Please contact our billing service at CBS (Computer Billing Service), 1-415-683-3223, if you have additional questions/concerns regarding your billing statement.

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