PARNASSUS HEIGHTS PODIATRY GROUP

A Professional Corporation

Diseases & Injuries of the Foot & Ankle

Joel R. Clark, DPM • Jamie Kim, DPM • Colin J. Traynor, DPM

PATIENT INFORMATION

Last: _____ First: _____ MI: _____

Nickname/Preferred Name: _____

Address: _____ Unit: _____

City: _____ State: _____ Zip: _____

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

SSN: ____ - ____ - ____ Email: _____

Sex (M or F): _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

INSURANCE & BILLING

Primary Insurance: _____ Secondary Insurance: _____

Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Subscriber Name: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber DOB: _____

If patient is under 18, please provide the person responsible for billing:

Name: _____ Phone: _____

Address: _____ Relation to Patient: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relation to Patient: _____

MEDICAL INFORMATION

Referring Doctor/Primary Care Physician: _____

PCP Phone: _____ Date Last Seen: _____

Pharmacy Name/Location: _____ Pharmacy Phone: _____

Have you ever seen a podiatrist? ☐ No ☐ Yes If yes, who and when? _____

INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize Parnassus Heights Podiatry Group to furnish information to insurance carriers concerning my illnesses and treatments and to my referring physician if so requested. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

Please initial if you will allow photographs to be taken of your feet for educational purposes only. _____

Thank you!

St. Mary's Medical Center
1 Schrader Street, Suite 510
San Francisco, CA 94117
T 415.759.2014 • F 415.759.2015
www.phpodiatry.com

PARNASSUS HEIGHTS PODIATRY GROUP

A Professional Corporation

Diseases & Injuries of the Foot & Ankle

Joel R. Clark, DPM • Jamie Kim, DPM • Colin J. Traynor, DPM

Date: _____
Shoe Size: _____
Height: _____
Weight: _____

Race:
- ☐ American Indian
- ☐ African American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ White
- ☐ Unknown/Other: _____

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown/Other: _____
- ☐ Decline to answer

Describe the problem and the DATE your symptoms began: **Side Affected:** ☐ Right ☐ Left ☐ Both

_____
_____
_____

Have any tests been done? ☐ X-rays ☐ CT scan ☐ MRI ☐ EMG ☐ NCT ☐ Other: _____

Have you ever had or do you presently suffer from:

1) Seizures ☐ Yes ☐ No
2) Stroke ☐ Yes ☐ No
3) Cardiac/Heart Problems ☐ Yes ☐ No
4) High Blood Pressure ☐ Yes ☐ No
5) Respiratory Problems ☐ Yes ☐ No
6) Cancer ☐ Yes ☐ No
If yes, site: _____
7) Diabetes ☐ Yes ☐ No
8) HIV ☐ Yes ☐ No
9) Hepatitis/Jaundice ☐ Yes ☐ No
10) GERD ☐ Yes ☐ No
11) Ulcer/GI Problems ☐ Yes ☐ No
12) Thyroid Disorder ☐ Yes ☐ No
13) Anxiety/Depression ☐ Yes ☐ No
14) Blood Clots/Phlebitis ☐ Yes ☐ No
15) Bleeding Disorder ☐ Yes ☐ No
16) Kidney/Bladder Infection ☐ Yes ☐ No
17) Psoriasis/Skin Rash ☐ Yes ☐ No
18) Arthritis ☐ Yes ☐ No
19) Have you had Cortisone? ☐ Yes ☐ No
If yes, site: _____
20) Reaction to Anesthesia ☐ Yes ☐ No
If yes, reaction: _____
21) Smoke Cigarettes ☐ Yes ☐ No
If yes, amount: _____
22) Drink Alcohol ☐ Yes ☐ No
If yes, amount: _____
23) Use Recreational Drugs ☐ Yes ☐ No
If yes, type: _____
If yes, frequency: _____

List any other medical conditions not mentioned above:

_____
_____
_____

List all MEDICATIONS you are presenting taking:

_____
_____
_____
_____

List all ALLERGIES:

_____
_____
_____

List all past surgeries (include dates):

_____
_____
_____

Review of systems:

- Lower back pain? ☐ Yes ☐ No
- Recent fevers, unintentional weight loss? ☐ Yes ☐ No
- Recent vision changes, double vision? ☐ Yes ☐ No
- Chest pain, palpitations? ☐ Yes ☐ No
- Shortness of breath, wheezing, coughing after exercise? ☐ Yes ☐ No
- Nausea, vomiting? ☐ Yes ☐ No
- New rashes? ☐ Yes ☐ No
- Dizziness, weakness, numbness, tingling? ☐ Yes ☐ No
- Depressed mood, sleep problems, anxiety? ☐ Yes ☐ No
- Joint swelling? ☐ Yes ☐ No

For female patients:

- *Are you pregnant, trying to get pregnant or breastfeeding?* ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

St. Mary's Medical Center
1 Schrader Street, Suite 510
San Francisco, CA 94117
T 415.759.2014 • F 415.759.2015
www.phpodiatry.com

PARNASSUS HEIGHTS PODIATRY GROUP

A Professional Corporation

Diseases & Injuries of the Foot & Ankle

Joel R. Clark, DPM • Jamie Kim, DPM • Colin J. Traynor, DPM

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Patient Name: _____ **DOB:** _____

I hereby authorize _____ to release my medical records to the following location:

Name: _____

Address: _____

Fax: _____ - _____ - _____ Phone: _____ - _____ - _____

Medical Records to be released:

- ☐ X-ray CD ($5 fee)
- ☐ Operative Report
- ☐ Lab Test Results
- ☐ Treatment Notes
- ☐ Other: _____
- ☐ MRI Films
- ☐ MRI Report
- ☐ Pathology Report
- ☐ ALL MEDICAL RECORDS

Signature of Patient: _____

Signature of Doctor: _____

*Depending on the request, additional copying/handling fees may apply.

St. Mary's Medical Center
1 Schrader Street, Suite 510
San Francisco, CA 94117
T 415.759.2014 • F 415.759.2015
www.phpodiatry.com

PARNASSUS HEIGHTS PODIATRY GROUP

A Professional Corporation

Diseases & Injuries of the Foot & Ankle

Joel R. Clark, DPM • Jamie Kim, DPM • Colin J. Traynor, DPM

FEDERAL HEALTH PRIVACY RULE CONSENT FORM

PRIVACY RULE
The Federal Government has developed regulations in an attempt to ensure the health care privacy of our patients. This means that we cannot use or disclose health information for the purpose of treatment, payment or health care operations without your written consent. As part of these regulations, we are required to inform you how this office utilizes, shares, and protects the health care information that we collect. Attached is a copy of our office policy and further detail regarding the Federal Health Privacy Rule.

You may revoke this consent at this time or you may request additional restrictions on how your health care information is used and disclosed for treatment, payment and health care operation purposes.

I agree with the Health Care Privacy Compliance being utilized by this office.

Date: _____

Printed Patient Name: _____

Signature of Patient: _____

St. Mary's Medical Center
1 Schrader Street, Suite 510
San Francisco, CA 94117
T 415.759.2014 • F 415.759.2015
www.phpodiatry.com