Naftoli H. Weingarten DPM PC
901 E San Antonio Dr. Long Beach CA 90807
Phone: (562) 422-3338 Fax: (562) 422-3339
Email: LBpodiatrist@gmail.com

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____
PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) _____
_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____
_____ _____
_____ _____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

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☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

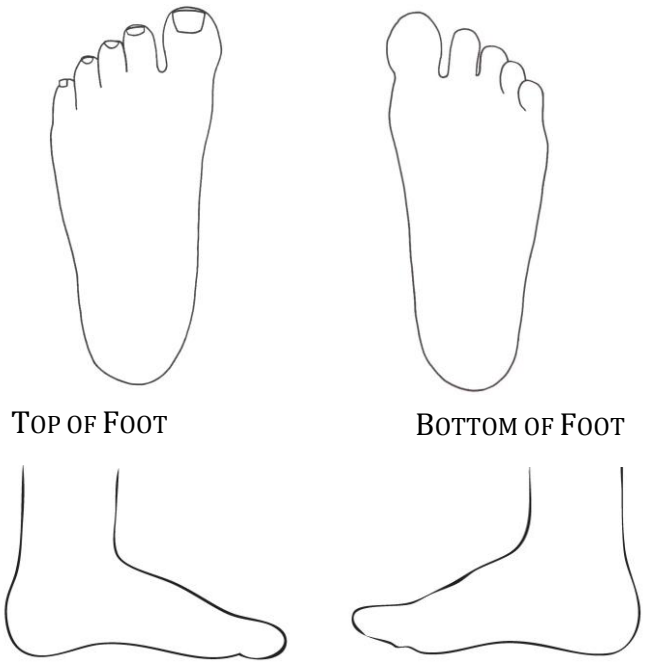
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

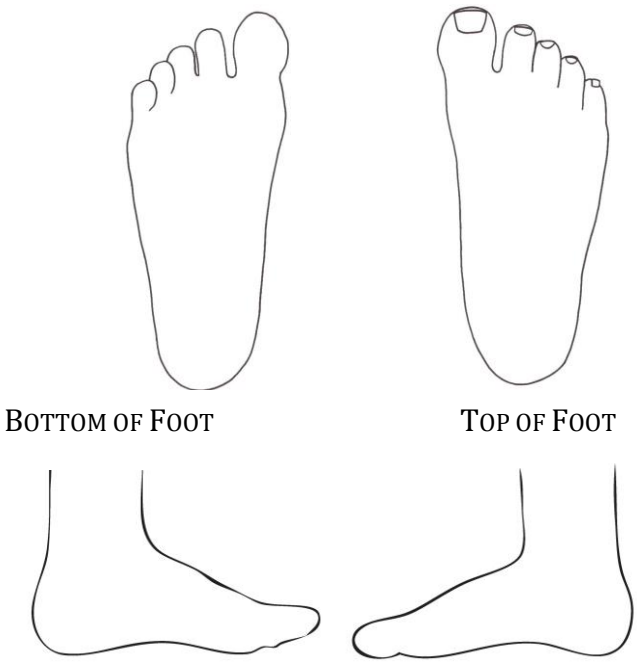
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT BOTTOM OF FOOT

RIGHT FOOT



BOTTOM OF FOOT TOP OF FOOT

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INSIDE OF FOOT | OUTSIDE OF FOOT | OUTSIDE OF FOOT | INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____
SIGNATURE OF DOCTOR

_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____
DATE

_____
SIGNATURE

_____
DATE

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Dear Patient,

We have created this letter to ensure you are aware of possible out-of-pocket costs to you for the podiatry care you receive today.

We request to keep a credit card on file to cover the balances that the health insurance company deems patient responsibility in regards to your current deductible.

Cardholder Name: _____

Cards Accepted – Visa, MasterCard, Discover, American Express

Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date: ___ ___ /___ ___ Security Code: ___ ___ ___ ___

(Security Code - 3 digits on the back of your card, except AMX - 4 digits on the front of the card)

Credit Card Billing Address _____

City_____ State_____ Zip_____

Authorized Signature _____

In the event that payment from your credit card is required, you will be notified by our office within a 24-hour period.

Please be aware that any and all information you provide today will be kept secure and is in compliance to HIPPA and PCI DSS rules and regulations.

We appreciate your attention to this matter and look forward to treating you and fulfilling all your current and future podiatry needs.

Sincerely,

Weingarten Foot and Ankle Center

Financial Policy for Weingarten Foot And Ankle Center

We are dedicated to providing great care to our patient's and assisting you in any way to achieve reimbursement for our services from your insurance company. We will send in the claims to the insurance company on your behalf. If there are services which are excluded from coverage by your specific policy, we are often not aware of this and so it is the patient's responsibility to know what their policy covers. (Exception: We check benefits prior to surgery in the hospital/surgery center to verify benefits).

Some services that we provide **may not be covered, or have limits on coverage**: 1) Debridement of toenails and trimming of calluses, 2) Durable medical equipment items such as braces, post-op shoes/cam walkers.

Medications, topical solutions and items we have available for purchase are non-covered items by all insurance plans and will not be billed to your insurance company for reimbursement. These items are to be paid for at the time of service.

Change of Coverage: Please let us know if you change your insurance and provide the office with the new card. Insurance companies allow only a small period of time to file claims. If we submit to the wrong company your claim may be denied by the correct company and the balance due becomes the responsibility of the patient. The only way we know if you have different insurance is if you tell us. Please provide us with your updated card to photocopy as soon as you receive one.

Copayments: Copayments are required when services are rendered per your contract with the insurance company. We accept VISA, MasterCard, American Express and Discover. You may also pay with cash or a check. We prefer to get to know you before paying with a check. New patients should use credit or cash for their copayments, please.

By my signature, I agree that I have read the above financial policy and agree to its terms. I further acknowledge that non-covered items/services are my financial responsibility.

Patient Signature/ Legal Guardian _____

Patient Name/Legal Guardian _____ Date_____

Privacy Notice Summary:

Uses of Health Information: We will use your health information to treat and assist other healthcare providers in treating you, to bill insurance claims for payment and for licensing, credentialing and training of students who are covered under our HIPPA policy in this office.

Your Authorization: We will obtain your authorization before releasing your private information to anyone other than those listed in the paragraph above.

Uses not requiring your Authorization: We may disclose your information in some circumstances such as: Family members involved in your care, limited research purposes, public health and safety purposes, Government audits and investigations, FDA reports, law enforcement authorities to protect the public, and when required by court orders.

Patient Rights: You have a right to access/copy health information, discuss your information confidentially with us, and restrict how the health information is used. If you would like a detailed Privacy Notice, please ask at our front desk.

I consent that I have read and understand the HIPAA Patient Privacy Rules.

Patient Signature/ Legal Guardian _____

Patient Name/Legal Guardian _____ Date_____