DR. SALMA AZIZ, DPM
FOOT AND ANKLE SPECIALTY GROUP

Welcome to our Office

Please Print

PATIENT INFORMATION

Date ________________ Home Phone ( ) _______________________ Email _______________________
Last Name ______________________ First Name ________________________ Middle Initial____ Sex M F
Street _________________________________ City _______________________ State _____ Zip ____________
Social Security # __________________ Driver's License _____________ Age ____ Date of Birth ____/____/___
Marital Status ________________ Children? ______________________ Ages ___________________________
Employer ____ Phone ( ) ______________________________
Street _______________________________ City ___________________ State __________ Zip ____________
Occupation ____________________________________ May we call you at work Y N Work hours__________

Spouse/Domestic Partner Information (If appropriate)

Home Phone ( ) _____________________________________
Last Name _______________________ First Name ________________________ Middle Initial____ Sex M F
Street _____________________________________ City ________________ State _______ Zip ___________
Social Security # __________________ Driver's License _____________ Age ____ Date of Birth ____/____/___
Employer ____ Phone ( ) ______________________________
Street ____________________________________ City ______________ State __________ Zip ____________

Financial Responsible Party (If different from patient)

Home Phone ( ) _____________________________________
Last Name _______________________ First Name _____________________ Middle Initial____ Sex M F
Street ___________________________________ City ______________________ State ____ Zip ___________
Social Security # __________________ Driver's License ____________ Age _____ Date of Birth ____/____/___
Employer ____ Phone ( ) ______________________________
Street _______________________________ City ________________________ State_____ Zip ____________
Occupation ____________________________________ May we call you at work Y N Work hours _________

Insurance Information

Primary Insurer ____________________________ Phone _________________ Group # __________________
Street ________________________________ City _______________ State _____ Zip ____________________
Insurance Id _______________________________________
Secondary Insurer _________________________ Phone _________________ Group # __________________
Street ________________________________ City _______________ State _____ Zip ____________________
Insurance Id _______________________________________

In case of an emergency

Who Should we contact? _______________________ relationship____________ Phone________________

Who may we thank for referring you? ____

Please read and sign below: I directly assign all medical and surgical benefits to Dr. Aziz. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize Dr. Aziz to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.
It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT.

____ ___________________________
Signature Required Date

DR. SALMA AZIZ, DPM
FOOT AND ANKLE SPECIALTY GROUP

PATIENT MEDICAL HISTORY - OVERVIEW

What is your foot/ankle problem? ____________________
____
____
When did problem begin? Date: ____________________
Describe any accident/event: ____________________
____
Is this problem work related? ❑ Yes ❑ No
First visit to a Doctor for this problem? ❑ Yes ❑ No
Previous x-rays? ❑ Yes ❑ No If Yes, Date: ____________
Where are they now? ____________________
Describe any previous treatment or home remedies?
____
____
____

Height: _________Weight: __________Shoe Size: ___________
How much are you on your feet at work?
❑ 20% ❑ 40% ❑ 60% ❑ 80% ❑ 100%
List any sports/activities:
____
Are you taking nutritional or diatary supliments (e.g. Ginkgo biloba, Ginseng, Echinacea)? ❑ Yes ❑ No
List

Do you smoke cigarettes? ❑ Yes ❑ No Packs/Day: ____Years:
Did you ever smoke? ❑ Yes ❑ No Packs/Day: ____Years:
Do you drink alcoholic beverages?
❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit
Do you use "recreational" drugs?
❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit

List
____

Have you been treated for:
❑ Low back pain ❑ Intoeing ❑ Heel pain
❑ Broken foot bone(s) ❑ Callouses ❑ Rash
❑ Hammertoes ❑ Neuroma ❑ Corns
❑ Ankle injury ❑ Knee pain ❑ Arch pain
❑ High arch feet ❑ Bunions ❑ Flat feet
❑ Ingrown nails ❑ Childhood foot problems

Do you have or have you ever been treated for:
❑ Diabetes ❑ Anemia ❑ Blood disease
❑ Hepatitis ❑ Phlebitis ❑ Heart trouble
❑ HIV ❑ High Blood Pressure ❑ Sleep Apnea*

*Do you use a CPAP machine? ❑ Yes ❑ No
Are you slow to heal after cuts? ❑ Yes ❑ No
Any abnormal bruising or bleeding? ❑ Yes ❑ No
Any pain in calves or buttocks when walking? ❑ Yes ❑ No
Is the pain relieved by rest? ❑ Yes ❑ No
Do your feet hurt at night? ❑ Yes ❑ No
Currently taking any prescription medications? ❑ Yes ❑ No
List: ____
____

Allergies to injection, oral or topical administration of:
Penicillin or other antibiotics? ❑ Yes ❑ No ❑ Don't Know
Narcotics?(Morphine, Codeine, Demerol…) ❑ Yes ❑ No ❑ Don't Know
Local anesthetics? ❑ Yes ❑ No ❑ Don't Know
Pain remedies? ❑ Yes ❑ No ❑ Don't Know
Adhesive tape? ❑ Yes ❑ No ❑ Don't Know
Any other drug, medication or treatment? ❑ Yes ❑ No ❑ Don't Know
If "yes" to any of the above, please explain: ____________________
____

Have you had a serious illness? ❑ Yes ❑ No
Have you been hospitalized or under lengthy medical care? ❑ Yes ❑ No
Have you had any surgery? ❑ Yes ❑ No
Do you have any implants? ❑ Yes ❑ No
Orthopedic (e.g. knee, hip, etc.) ❑ Yes ❑ No
Cardiac (e.g. valve, pacemaker, graft, etc.) ❑ Yes ❑ No
Cosmetic (e.g. breast, facial, etc.) ❑ Yes ❑ No
If "yes" to any of the above, please explain: ____________________
____
____

3 PATIENT PHYSICIANS

Did your Family Physician (PCP) or other Specialist refer you? ❑ Yes ❑ No

Family Physician:
Date last seen: ________________ Phone: ( )
City: ____________________________ State: ______ Zip:
Are you here for a consultation? ❑ Yes ❑ No
Are you here for a surgical evaluation? ❑ Yes ❑ No

Specialist Dr:______________________________ Specialty:
Date last seen: ________________ Phone: ( )
City: ______________________ State: _____ Zip:
Are you here for a 2nd opinion on surgery? ❑ Yes ❑ No
Did you independently come for an opinion? ❑ Yes ❑ No

4 FAMILY HISTORY

Has any blood relative had: If "Yes," please indicate who

Tuberculosis? ❑ Yes ❑ No ________________________________
Cancer or tumor? ❑ Yes ❑ No ________________________________
High blood pressure? ❑ Yes ❑ No ________________________________
Heart trouble? ❑ Yes ❑ No ________________________________
Diabetes? ❑ Yes ❑ No ________________________________
Birth abnormalities? ❑ Yes ❑ No ________________________________
Arthritis? ❑ Yes ❑ No ________________________________
Stroke? ❑ Yes ❑ No ________________________________
Foot problems? ❑ Yes ❑ No ________________________________

DR. SALMA AZIZ, DPM
FOOT AND ANKLE SPECIALTY GROUP

Date: ___________________

Name: ______________________________________

SALMA AZIZ, DPM
FOOT AND ANKLE SPECIALTY GROUP

Web Site: www.yourfootdoc.com

Mission Health Center
22032 El Paseo, Suite 140
Rancho Santa Margarita, CA 92688
Phone: 949-766-8505
Fax: 949-766-5782

INSURANCE BENEFITS AND ELIGIBILITY

As a courtesy to our patients we will bill your insurance provider. However, you will be responsible for any non-covered fees, including deductible and co-payments.
Please answer the following questions prior to your first appointment. You may need to contact your insurance provider for verification. Please have your insurance card ready when you call.

Patient name: ________________________ID#: ________________Group #: _________________

Insurance provider phone: ( ) ______________________

Claims billing address: ____

City: _____________State: _____________________________Zip: _______

Check applicable: ❑ PPO ❑ HMO ❑ Private ❑ EPO ❑ IPA

Policy effective date:

Deductible: _________ Has deductible been met? ❑ Yes ❑ No Co-pay amount: __________

Are there financial limits on podiatric care? ❑ Yes ❑ No Amount: _____________ _______________ Benefit Rate: ❑ In-Network _________ ❑ Out of Network

Is prior authorization required from a primary care physician (PCP)? ❑ Yes ❑ No

Is your doctor (this appointment) a provider on your plan? ❑ Yes ❑ No

Are custom orthotic devices a covered benefit? ❑ Yes ❑ No % Rate _______Limit ________

Is a letter of medical necessity required for orthotic devices? ❑ Yes ❑ No

Name of person contacted at insurance provider: ____

Date of contact: ________________

_____________________________ Patient (Guardian) Signature

_____________________________ Date

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Date: ________________

Patient Name ____

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NOTIFICATION OF BILLING PROCEDURES

Medicare—Unauthorized/Unbillable Charges

Medicare requires a minimum of 60 days between visits for at risk patient footcare and nail grinding. If the diagnosis changes (for example, fracture, trauma, infections, etc.) the visit may be billed under
the new diagnosis. Any charges occurring outside these guidelines will be the responsibility of the patient.

Non-covered Services

Insurance providers will decline payment for non-covered services or supplies. Post-op shoes, certain ankle braces, orthotic devices and pads are some examples of non-covered supplies.

Unauthorized Visits

Some insurance providers require prior authorization for office visit or procedure. It is the patient's responsibility to obtain authorization before their office visit. If authorization is not obtained, the patient will be responsible for all costs incurred by their office visit.

Deductible

The deductible is the patient's responsibility. The patient's insurance provider will be billed to determine the amount applied toward the patient's deductible. Insurance information must be available on the day of the visit or full payment will be required at that time.

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Date: ______________

Patient Name: ____

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NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

This notice describes how patient protected health information may be used and disclosed and the patient's right to access to this information.
Please review carefully.

The ***Health Insurance Portability & Accountability Act of 1996*** **("HIPAA")** requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. Any misuse personal health information is subject to penalties.

❑ We may use and disclose patient medical records only for the following purposes:
   - ❑ **Treatment**: providing, coordinating, or managing health care and related services by one or more health care providers.
   - ❑ **Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)
   - ❑ **Health care operations**: conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.

❑ We may create and distribute non-identified health information by removing all references to individually identifiable information.

❑ We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.

❑ Any other uses and disclosures may be made only with patients written authorization. Patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on patient authorization.

❑ We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.

❑ Patients have the following rights with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer:
   - ❑ The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient. We are not required to agree to a requested restriction. However, if we do, we must abide by it unless patient agrees in writing to remove it.
   - ❑ The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
   - ❑ The right to inspect and copy protected health information.
   - ❑ The right to amend protected health information.
   - ❑ The right to receive an accounting of disclosures of protected health information.
   - ❑ The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.

____ ____________________________

Patient (Guardian) Signature   Date