



DR. ANNALISA Y. CO | 5931 STANLEY AVENUE, SUITE 4, CARMICHAEL, CA 95608 | PH (916) 244-7630
WWW.OLYMPICFOOTANDANKLE.COM

NEW PATIENT FORM
(PLEASE PRINT)

DATE: ___/___/___

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

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE: _____

MAY WE LEAVE A MESSAGE?

E-MAIL: _____ YES/NO HOME PHONE #: (____) ____ - ____ YES/NO

MOBILE PHONE #: (____) ____ - ____ YES/NO WORK PHONE #: (____) ____ - ____ YES/NO

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

-ETHNICITY: () HISPANIC/LATINO () NON-HISPANIC/NON-LATINO () DECLINE TO SPECIFY

-PREFERRED LANGUAGE: () ENGLISH () OTHER _____

-RACE: () AMERICAN INDIAN OR ALASKAN () ASIAN () BLACK OR AFRICAN-AMERICAN () NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER () WHITE OR CAUCASIAN () DECLINE TO SPECIFY

NEXT OF KIN CONTACT : _____ RELATIONSHIP: _____
FIRST LAST

PHONE #: (____) ____ - ____

PRIMARY CARE DOCTOR: _____ PHONE: _____

ADDRESS _____

WHO CAN WE THANK FOR REFERRING YOU TO OLYMPIC FOOT AND ANKLE?

() DOCTOR () FRIEND () INSURANCE () INTERNET () OTHER _____

NAME: _____ PHONE: _____

ADDRESS _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____

ID # _____ GROUP # _____ EFFECTIVE DATE __/__/__

(ON THE BACK OF YOUR INSURANCE CARD) WHAT IS THE **PROVIDER** PHONE NUMBER: (_____) _____ - _____

POLICY HOLDER NAME: _____ DATE OF BIRTH __/__/__

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE NAME: _____

ID # _____ GROUP # _____ EFFECTIVE DATE __/__/__

(ON THE BACK OF YOUR INSURANCE CARD) WHAT IS THE **PROVIDER** PHONE NUMBER: (_____) _____ - _____

POLICY HOLDER NAME: _____ DATE OF BIRTH __/__/__

RELATIONSHIP TO PATIENT: _____

YOUR MEDICAL HISTORY

PLEASE LIST ALL MAJOR **EVENTS OR HOSPITALIZATIONS** (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR **SURGERIES**:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES (PLEASE LIST ALL MEDICATIONS, FOODS, ENVIRONMENTALS):

NAME	ONSET/WHEN?	REACTION?	MILD/MODERATE/SEVERE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? C=CURRENT P=PREVIOUS

REFLUX	C	P	FIBROMYALGIA SYNDROME	C	P	TUBERCULOSIS	C	P
ANEMIA	C	P	GOUT	C	P	OSTEOPOROSIS	C	P
ARTHRITIS WHERE?	C	P	MYOCARDIAL INFARCTION (HEART ATTACK)	C	P	PERIPHERAL VASCULAR DISEASE	C	P
ASTHMA	C	P	HEART DISEASE	C	P	RHEUMATOID ARTHRITIS	C	P
BACK ACHE OR PAIN WHERE? LOW / MID / HIGH	C	P	HEPATITIS: TYPE A / B / C	C	P	SICKLE-CELL DISEASE	C	P
BLOOD COAGULATION DISORDER (ABNORMAL BLEEDING)	C	P	HIV+ / AIDS	C	P	DISORDER OF SKIN WHAT?	C	P
DEEP VENOUS THROMBOSIS (DVT OR BLOOD CLOTS)	C	P	HYPERTENSIVE DISORDER (HIGH BLOOD PRESSURE)	C	P	SLEEP APNEA	C	P
CHRONIC OBSTRUCTIVE LUNG DISEASE (EMPHYSEMA / BRONCHITIS)	C	P	HYPERCHOLESTEROLEMIA (HIGH CHOLESTEROL)	C	P	ULCER ANKLE / FOOT / TOE	C	P
NEOPLASM (CANCER) WHERE?	C	P	KIDNEY DISEASE	C	P	CEREBROVASCULAR ACCIDENT (STROKE)	C	P
CHARCOT-MARIE-TOOTH	C	P	LIVER DISEASE	C	P	HYPERTHYROIDISM	C	P
HEART FAILURE	C	P	MIGRAINE	C	P	HYPOTHYROIDISM	C	P
DIABETES	C	P	NEUROPATHY	C	P	VASOVAGAL SYNCOPE (FAINTING)	C	P

LIST OTHER CONDITIONS:

FAMILY HISTORY (PLEASE LIST ALL FAMILY ILLNESSES):

ILLNESS

GRANDPARENT / MOTHER / FATHER / BROTHER / SISTER?

SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY TO YOU):

- SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED
 NEVER SMOKED TOBACCO FORMER SMOKER CURRENT EVERYDAY SMOKER ___ PACKS/DAY FOR ___ YEARS
 FORMER ALCOHOL ABUSE CURRENTLY DRINKS BEER CURRENTLY DRINKS WINE
 CURRENTLY DRINKS LIQUOR
 FORMER RECREATIONAL DRUG USER CURRENTLY USES RECREATIONAL DRUGS
 TYPE _____
 RETIRED DESK WORK WORKS ON FEET OCCUPATION: _____
 EXERCISES OCCASIONALLY EXERCISES OFTEN
 WALK RUN BIKE DANCE ELLIPTICAL YOGA OTHER _____

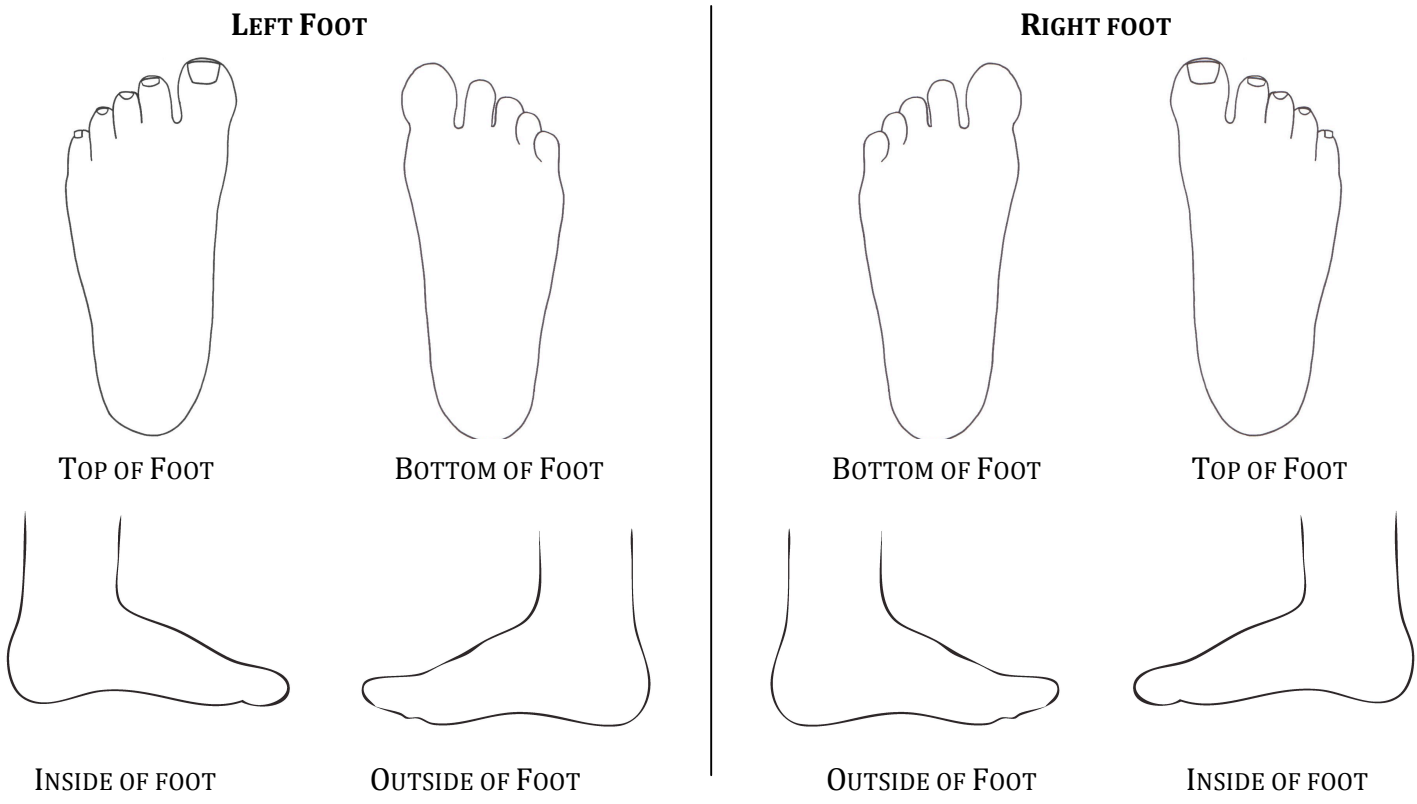
MEDICATIONS (PLEASE INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS):

NAME	DOSE (#MG, ML OR UNITS)	FREQUENCY

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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



HOW LONG HAS THIS PROBLEM BEEN PRESENT? _____ DAYS / WEEKS / MONTHS / YEARS

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

HAVE YOU HAD THIS PROBLEM BEFORE? YES, WHEN? _____ No

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ No
IF YES, WAS IT A WORK-RELATED INJURY? YES No

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

HOW WOULD YOU RATE YOUR PAIN **RECENTLY** 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 REST OR AT NIGHT
 BAREFOOT DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE
 RUNNING OTHER _____

WHAT TREATMENTS HAVE YOU TRIED FOR THIS PROBLEM? _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL **BETTER**? _____

DOES THIS PROBLEM AFFECT YOUR LIFESTYLE OR ABILITY TO WORK? _____

WHAT IS YOUR SHOE SIZE? _____ WOMEN/MEN

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

SIGNATURE

DATE

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT



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Consent for Photo, Video, or Other Imaging for Media or Education

Patient's Name: _____ Patient's Date of Birth: _____

Dr. Annalisa Y. Co often lectures nationally to other practitioners. She typically uses photographs and video taken of real patients' feet/ankles within powerpoint presentations in order to teach and display different types of problems. These images are of the foot/ankle alone without the use of any faces or other parts of the body making patient identification almost impossible. Signing this consent gives Dr. Co permission to have photographs, videotaped images, or other images made of my foot and ankle. I understand and agree that these images may be used by Olympic Foot and Ankle and Dr. Co for the purposes outlined below.

- Teaching purposes, which includes being shown to other patients and other doctors
- Advertisements by Olympic Foot and Ankle
- Placement on Olympic Foot and Ankle's website: www.olympicfootandankle.com or other business related social media outlets

Signature of Patient / Legal representative

If Legal representative, Relationship to patient

Date

I do **NOT** wish to have images/video taken.

Signature of Patient / Legal representative

If Legal representative, relationship to patient

Date



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Patient Financial Policy

Welcome To Olympic Foot and Ankle. Thank you for choosing us for your foot and ankle care. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our **FINANCIAL POLICY** that we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If Olympic Foot and Ankle is a participating provider with your insurance plan, we will submit the claim for you to your insurance company. To do this we must have complete and accurate insurance information including social security number, home address, and phone number, and a copy of your identification card. *Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays.* It is **your responsibility** to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become **your responsibility to pay.**

NON-INSURED: If you do not have insurance or the doctor is not a participating provider with your insurance plan, full payment is due at time of each visit.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by cash, check or credit card. There will be a \$25.00 charge for returned checks. Delinquent accounts of greater than 120 day may be referred for collection.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES: Please be prepared to pay all co-payments and deductibles at the time of service.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. **A \$25.00 charge will be charged for missed appointments or same day cancellations/rescheduling.**

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase.

Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Signature of Patient/Responsible Party:

Date: _____

Please let us know if you would like a copy of our financial policy.



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HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;

This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Patient or Legal Representative _____

Printed Name of Patient or Legal Representative _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
 - Communication barrier prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Others (please specify):
-
-



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