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: _____

HOME ADDRESS_____

**MAY WE LEAVE A MESSAGE?**

E-MAIL: _____YES/NO

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

MOBILE PHONE #: (____) _____-_____ YES/NO CAN WE SEND TEXT REMINDERS? YES/NO

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-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

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NEXT OF KIN CONTACT: : _____ _____ RELATIONSHIP: _____
FIRST LAST
PHONE #: (____) ____-_____

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PRIMARY CARE DOCTOR: _____ PHONE: _____

WHO CAN WE THANK FOR REFERRING YOU TO OLYMPIC FOOT AND ANKLE?
( ) DOCTOR ( ) FRIEND ( )INSURANCE ( )INTERNET ( )OTHER _____

NAME: _____ PHONE: _____

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

## YOUR MEDICAL HISTORY

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**:

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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

| NAME | DOSE (#MG, ML OR UNITS) | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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

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

_____

_____

_____

_____

**FAMILY HISTORY** (PLEASE LIST ALL FAMILY ILLNESSES):

ILLNESS GRANDPARENT/MOTHER/FATHER/BROTHER/SISTER?

_____

_____

_____

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

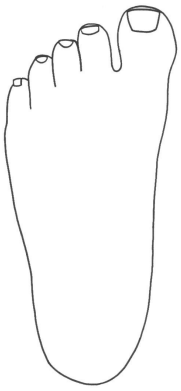
☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
☐ NEVER SMOKED TOBACCO ☐ FORMER SMOKER ☐ CURRENT EVERYDAY SMOKER ___ PACKS/DAY FOR ____ YEARS
☐ FORMER ALCOHOL ABUSE ☐ CURRENTLY DRINKS BEER ☐ CURRENTLY DRINKS WINE
☐ CURRENTLY DRINKS LIQUOR
☐ FORMER RECREATIONAL DRUG USER ☐ CURRENTLY USES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

**CURRENT PROBLEM**

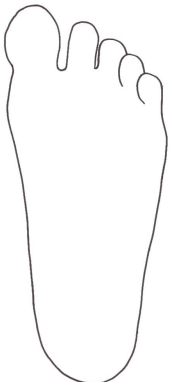
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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

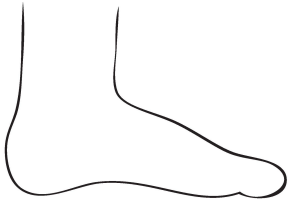
**LEFT FOOT**



TOP OF FOOT



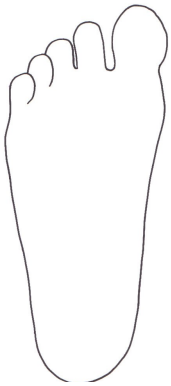
BOTTOM OF FOOT



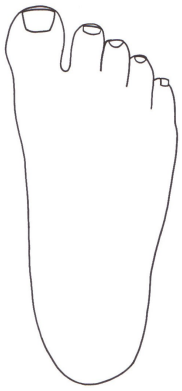
INSIDE OF FOOT

OUTSIDE OF FOOT

**RIGHT FOOT**

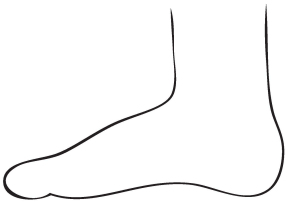


BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

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

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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

# 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 practioners. 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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