Podiatry Office
Ralph P. Hoyal, DPM
Rachel A. Hoyal, DPM
1041 4th St., Suite B
Santa Rosa, CA 95404
(707) 546-2107 FAX# (707) 573-0315

Patient Name:_____ Gender: ( )Male ( )Female ( )Other

Date of Birth:_____/_____/_____ Home Phone:_____ Cell Phone:_____

Address:_____

Primary Care Physician:_____ Date Last Seen:_____/_____/_____
Do you see other specialists? If so please fill out the following:

Vascular:( ) No ( )Yes:_____

Cardiologist: ( )No ( )Yes:_____

Endocrinologist:( )No ( )Yes:_____

Nephrologist:( )No ( )Yes_____

Language:_____ Race/Ethnicity:_____

Referred By:_____

Employer/School:_____ Occupation:_____

Pharmacy & Location:_____

Insurance Information:

Please present Insurance Cards for Copying/Scanning

Primary Insurance:_____Insured's Name:_____

Secondary Insurance:_____ Insured's Name:_____

Name:_____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions please discuss them with our office staff.

I hereby authorize my insurance carrier to pay medical benefits directly to Drs. Hoyal. I authorize the doctors to release any information acquired in the course of my treatment needed for this medical insurance claim. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or other third party is involved with payment. I am responsible for all co-pays, and co-insurance amounts, non covered supplies and services, and annual deductibles.

- I agree to pay all collection expenses including a $40.00 returned check fee, attorney's fees, court costs, and filing fees. Payments for services are expected at the time they are rendered unless other arrangements have been made. We accept cash, check, Visa and Master Card.
- If you cancel your appointment without giving 24 hours notice, or if you No Show, you will be charged a $75.00 fee.
- Our relationship is with you, not your insurance company; we file insurance claims as a courtesy to you. I acknowledge and agree to the above:

Signature of Responsible Party:_____ Date:_____

Name:_____

Patient Medical History:

Patient Name: _____ Height:_____ Weight:_____

Allergies: _____

Medications (Please print names from your medicine bottles and dosage) :

_____

_____

_____

Do you have or have you ever been treated for any of the following? :

[ ] Diabetes [ ] High Blood Pressure [ ] Liver Disease [ ] Heart Disease or Attack [ ] Stroke

[ ] Cancer _____ [ ] High Cholesterol [ ] Stomach Ulcer [ ] HIV/AIDS [ ] Reflux

[ ] Hepatitis Type _____ [ ] Asthma [ ] COPD [ ] Osteoporosis [ ] Kidney Disease

[ ] Seizures [ ] Arthritis [ ] Rheumatoid Arthritis [ ] Thyroid (Hyper/Hypo) [ ] Parkinson 's disease

[ ] Psoriasis [ ] Multiple Sclerosis [ ] Fibromyalgia [ ] Gout [ ] Depression [ ] Anxiety

[ ] Blood Clots [ ] Lupus [ ] Psychiatric Disorder _____ [ ] Emphysema

[ ] Circulation Problems [ ] Mitral Valve Prolapse [ ] Neuropathy [ ] Pacemaker [ ] Tuberculosis

[ ] Pain Syndrome [ ] Pneumonia [ ] Reynaud's [ ] Sickle Cell Anemia [ ] Skin Disorder

[ ] Sleep Apnea [ ] Other:_____

Family History

Does your family have a history of any of the following?

[ ] Diabetes [ ] Cancer _____ [ ] Coronary Artery Disease [ ] Heart Disease

[ ] High Blood Pressure [ ] Stroke [ ] Thyroid Disease [ ] Rheumatoid Arthritis [ ] Blood Clots

[ ] Other: _____

Name:_____

Surgical History:

Type of Surgery:	Date:	Surgeon:
Type of Surgery:	Date:	Surgeon
Type of Surgery:	Date:	Surgeon:

Family History

Does your family have a history of any of the following?

[ ] Diabetes [ ] Cancer _____ [ ] Coronary Artery Disease [ ] Heart Disease

[ ] High Blood Pressure [ ] Stroke [ ] Thyroid Disease [ ] Rheumatoid Arthritis [ ] Blood Clots

[ ] Other: _____

Social History:

Do you use any of the following?

Tobacco: [ ] No [ ] Yes Type: _____Duration/Amount: _____Quit Date:_____

Alcohol Use: [ ] No [ ] Yes Amount: _____ Frequency: _____

Recreational Drug Use: [ ] No [ ] Yes Type and Frequency: _____

Hobbies/Sports: _____

Code Status: ( ) Full Code ( ) DNR(Do Not Resuscitate)

Patient/Guardian Signature: _____Date: _____

Name: _____

History of Current Foot/Ankle Problem

Did the problem result from a specific injury? [ ] No [ ] Yes

Please describe: _____

_____

Where is your pain located? [ ] Toe [ ] Heel [ ] Ankle [ ] Ball of foot [ ] Arch [ ] Left [ ] Right [ ] Both [ ] Other: _____

_____

What is your complaint?

_____

_____

How long have you had this complaint/condition?

_____

_____

Please rate your pain on a scale of 1-10 (10 being the most painful):

At rest: 1 2 3 4 5 6 7 8 9 10 **At its worst**: 1 2 3 4 5 6 7 8 9 10

Is the pain: [ ] Constant [ ] Occasional [ ] Sharp [ ] Dull [ ] Aching [ ] Stabbing [ ] Throbbing [ ] Radiating/Traveling

Other: _____

What symptoms are you experiencing?

[ ] Locking [ ] Numbness [ ] Giving Away [ ] Popping [ ] Tingling [ ] Burning [ ] Grinding [ ] Swelling [ ] Bruising

Other: _____

Does anything make your symptoms feel better?

_____

Does anything make your symptoms feel worse?

_____

Have you seen another physician for this problem?

_____

What treatments have you tried? [ ] Nothing [ ] Physical therapy [ ] injections [ ] Bracing [ ] Icing [ ] Compression [ ] Medications [ ] Shoe change [ ] Arch support [ ] Massage

[ ] Other_____

Name:_____

Have you had any of the following tests/studies?

\

Tests:	Date:	Facility:
X-RAYS		
MRI/CT SCAN		
NERVE STUDY		
BLOOD TESTS		
CR:		

Signature: _____ Date: _____

Thank you for completing these forms. We appreciate your efforts in filling them out completely. Please bring these forms with you to your appointment along with your insurance cards and with copies of any testing you have had performed.

Name:_____

Please also sign the HIPAA form as this is a federal requirement to protect you for all disclosure of your health information.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND MEDICAL RECORDS RELEASE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

The following people may be contacted regarding my care:

Name:_____ Telephone Number:_____

Name:_____ Telephone Number:_____

Responsible Party's Signature:_____ Date:_____