**Christyn Marshall, D.P.M, AACFAS**
**Jenny Lam, D.P.M, AACFAS**
**2301 Camino Ramon Suite 290 San Ramon, CA 94583**
**Located in Bishop Ranch 11**
**Phone: (925) 831-1898**
**Fax: (925) 831-4910**

*Thank you for choosing our office for your podiatric care. In order to serve you properly, please fill out the following information as legibly as possible. All information is confidential.*

**Date**_________________________

## Personal Information

Patient Name: ____________________________________________ DOB: _____________________ Age: ________________

Address: ____________________________________________ City: ________________ State: _________ Zip: _____________

Home Phone ________________________________________Cell Phone ________________________________________________

EMAIL ADDRESS______________________________________________________________________________

Marital Status (circle one): Single Married Widowed Divorced Male _______ Female ________

Ethnicity (Select One): Hispanic / Non-Hispanic / Decline

Preferred Language: ____________________ Decline

Race (Select One): White / Black / Native American / Asian / Pacific Islander / Other / Decline

**Please enter patient information if over 21 or parent information if under 21**

Drivers License#:______________________________ **OR** SS#:______________________________________

Occupation: ____________________________________________________________________________________

Employer: ___________________________________________________ City: _________________________ State: __________________

Emergency Contact: _____________________________________ Relationship: __________________ Phone: _______________________

Is this injury work-related? ______________________ Is this injury related to a motor vehicle accident? _______________________

Guarantor Name: _____________________________________________ DOB: _________________ Phone: ________________________________

**Preferred Pharmacy** (include specific location): ________________________________________________

## Insurance Information

**(* INDICATES REQUIRED FIELD, ALONG WITH COPY OF INSURANCE CARD)**

*Primary Insurance: __________________________________ *Subscriber Name: ________________________ *DOB: _______________

*ID Number: _________________________________ *Group Number: ___________________ Group Name: ______________________

Secondary Insurance: ________________________________ Subscriber Name: ________________________DOB: __________________

ID Number: __________________________________ Group Number: ___________________ Group Name: _______________________

## Other Information

**Release of Benefits and Information: I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that I am requesting services that may not be a covered benefit with my insurance carrier and I agree to pay for these services personally if necessary. I agree to any co-pays due at the time service is rendered. I authorize the doctor or insurance company to release any information required to assist in the collection of monies due, and I authorize payment to be paid directly to this office. If it becomes necessary to seek third party services for collection of monies owed, I agree to pay for all costs and expenses, including reasonable attorney fees and court cost.**

**Patient Signature (guarantor if patient is a minor):** ____________________________________________ **Date:** ______________

**PAST MEDICAL HISTORY**
**Circle all that apply:**

| Anemia | Epilepsy | High Cholesterol | Mitral Valve Prolapse | Kidney Disease |
|---|---|---|---|---|
| Bleeding Disorders | Gout: Last Flare | High Blood Pressure | Nerve Disorders | Rheumatic Fever |
| Cancer | Heart Problems | Thyroid Disorders | Neurological Disorders | Arthritis |
| Diabetes<br>Type I or Type II | Hepatitis | Lung/Respiratory Disorders | Stroke | Other |

Please list any serious illnesses, surgeries, or hospitalizations including the dates they occurred:

______________________________________________________________________

**Allergies and reactions:**

**Medications:** Please list all current medications (please write as legibly as possible)

Height: ______________ Weight: _______________ Shoe Size: __________________

What is your foot/ankle problem? ______________________________________________ Right _______ Left _______

When did it begin? __________________________________________________________________________

Did you have an injury? Yes______ No______

What home remedies have you tried? _______________________________________________________

Any previous foot or ankle surgery? Date? ___________________________________________________

During the course of the day how often are you on your feet? 20% 40% 60% 80% 100%

Please list any sports/ Activities participated in: ___________________________________________

Is this your first time seeing a podiatrist? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO Packs a day ____ Years _____ Are you a past smoker? ☐ YES ☐ NO

Do you use tobacco products: Cigarettes _______Vape_____ Smokeless tobacco_______

Do you drink? ☐ YES ☐ NO If yes, how often? ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

**FAMILY (PRIMARY CARE) PHYSICIAN INFORMATION**

NAME: ____________________________ PHONE:__________________FACILITY NAME:____________________________

Who referred you to this office?: ___________________________________________________________________________

Are you currently seeing a specialist for any reason? ☐YES ☐NO

Explain: ____________________________________________________________________________________________________

Did a specialist refer you to us? ☐YES ☐ NO

Office Financial Policy / HIPAA policy acknowledgment/Virtual Scribe

Our office will bill your insurance for you. Please present a current insurance card/cards to our office staff. Always indicate which insurance is the prime policy. I understand that my insurance card is not a guarantee of payment and that I am personally responsible for any professional fees resulting from my visit with the doctor including but not limited to : co-pays, deductibles, out of network fees, non-covered benefits or treatments, and any other exclusions or limitations of my insurance coverage. All co-pays are due at the time of service. Our office accepts all major credit cards for your convenience.

All appointments must be cancelled 24 hours in advance of scheduled appointment time.

A $10.00 returned check fee will be charged to account for all NSF checks.

A $40.00 fee will be charged for all missed appointments.

**A virtual scribe will dictate chart notes for your visit. Signing below indicates you have been informed of this practice.

I have read and understand your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time to requested an updated copy.

I authorize Dr. Marshall, Dr. Lam and the office staff to leave messages at the following numbers:

Home Phone (________) _________________________

Cell Phone (________) ________________________

PLEASE LIST THE NAME OF ANY OTHER PERSON WE CAN LEAVE INFORMATION WITH:

NAME:___________________________________RELATIONSHIP:________________PHONE______________________

I, the undersigned authorize payment directly to Dr. Marshall and Dr. Lam. I understand I am financially responsible for all charges whether or not paid by my insurance. I have presented my current insurance card today and I understand if this card is deemed inactive, not current or invalid for any reason, I will pay the pay the visit promptly myself and then seek reimbursement from my insurance company. If I am an HMO I am responsible for obtaining my initial referral. I am responsible for my copayment at each visit. I hereby authorize the office to release all information necessary to secure payment of benefits.

I fully understand all of the above policies and I am aware that Dr. Marshall and Dr. Lam are licensed and regulated by the Board of Podiatric Medicine.

Signature of patient_________________________________________________________

Signature of parent/guardian if patient is under 18 years_____________________________