McDowell Orthopedics & Podiatry Group (916) 961-3434 (916) 961-0540 -fax reception@mcdowellpodiatry.com
St. George Medical Center 6620 Coyle Ave., Suite 202 Carmichael, CA 95608

Patient Registration (Please Print Clearly)

Date________ Referring Physician ______________________________ Primary Care Physician ______________________________

Patient Name____
Last First MI

Date of Birth____________________________ SSN____ Sex ☐ Male ☐ Female

Address____
Street City State Zip Code

Home Phone__________________________Mobile Phone_______________________ Work Phone_______________________

Authorization to leave voice mail ☐ Yes ☐ No Authorization to leave text message ☐ Yes ☐ No

E-mail Address______________________________________ Contact Preference ☐ Home Phone ☐ Mobile Phone ☐ Work Phone

Family Member or Caregiver____
Name Preferred Phone Email

Preferred Language_________________ Race_________________ Ethnicity______________ Decline to Answer(please check)☐

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

How did you hear about us? ☐ Advertising ☐ Primary Care Physician ☐ Specialist Physician ☐ Hospital ☐ Insurance Company ☐ Internet ☐ Family/Friend ☐ Patient in the Practice Print Name____

Specify if other ____

Preferred Pharmacy________________________________ Address or Phone Number__________________________________

Preferred Lab_____________________________________ Address or Phone Number__________________________________

Preferred Imaging Center___________________________ Address or Phone Number__________________________________

Parent or Guardian

Name____Relationship____

Home Phone____Mobile Phone____

Emergency Contact

Name____ Relationship____

Home Phone____ Mobile Phone____

Employment

Employer____Occupation____

Address____
Street City State Zip Code

Primary Insurance Information:

Insurance Company_______________________________Subscriber/Guarantor____

Subscriber Date of Birth_____________________ Member ID___________________________ Group Number ______________

Secondary Insurance Information:

Insurance Company_______________________________Subscriber/Guarantor____

Subscriber Date of Birth_____________________ Member ID___________________________ Group Number______________

Tertiary Insurance Information:

Insurance Company_______________________________Subscriber/Guarantor____

Subscriber Date of Birth_____________________ Member ID___________________________ Group Number______________

Authorization For Treatment

Printed Patient Name___________________________________ Printed Signer Name________________________________

Signature of Patient, Parent, or Guardian ____ Date______________

Relationship to Patient __________________________ ☐ Self

Patient Name__________________________

Clinical Interview

Patient Name____ Date of Birth______________
Last First MI
Please explain the reasons for today's visit ____

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History of Current Symptoms

Onset or Date of Injury________________________ Occurrence ☐ New Injury or Symptom ☐ Re-occurrence

How did the injury occur_____________________________________ ☐ N/A Work Related ☐ Yes ☐ No Auto Accident ☐ Yes ☐ No

Injury or Symptom Site ☐ Left ☐ Right ☐ Bilateral (Both) ☐ Top ☐ Bottom ☐ Left Side ☐ Right Side ☐ Bilateral (Both) Sides

Symptoms ☐ Pain ☐ Burning ☐ Numbness ☐ Redness ☐ Swelling ☐ Tingling ☐ Aching ☐ Drainage ☐ Other________________________

Severity ☐ Mild ☐ Moderate ☐ Severe When are the symptoms at their worst ☐ Morning ☐ Daytime ☐ Night ☐ Other______________

Diagnostic Testing ☐ X-Ray ☐ MRI ☐ CT Date and Location____

What makes it better____ What makes it worse__________________________________

Previous Treatments____ Hand Dominance ☐ Left ☐ Right

Working Status ☐ Regular Duty ☐ Modified Duty ☐ Disabled ☐ Retired ☐ Not Working ☐ Other__________________________________

Additional Information____

____

Are you currently seeing a Cardiologist? ☐ Yes ☐ No If yes, who is the physician?____

Are you currently seeing a Vascular Surgeon? ☐ Yes ☐ No If yes, who is the physician? _____________________________________

Allergies

Do you have any Medication Allergies? ☐ Yes ☐ No If yes, please list medication(s) and reaction(s)__________________________

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Do you have any Latex Allergies? ☐ Yes ☐ No Do you have any Tape Allergies? ☐ Yes ☐ No

Do you have any Other Allergies? ☐ Yes ☐ No If yes, please specify____________________________________

Medication List

Please list all medications you are currently taking, including the dosage and frequency. Include all over the counter medications, contraceptives, herbal drugs or supplements Medication List Attached ☐ Yes ☐ No

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Vitals

Height______________________________ Weight___________________________ Pain Scale (Circle) 1 2 3 4 5 6 7 8 9 10

Family Medical History

No Past Family Medical History ☐						
	Father	Mother	Brother	Sister	Other	Notes (if other indicated, specify relation)
Anxiety Disorder						
Cancer (Specify type & status in notes)						
Diabetes						
Heart Attack (MI)						
Hypertension						
Peripheral Neuropathy						
Peripheral Vascular Disease						
Stroke						

 Patient Name_______________________

Social History

Smoker ☐ Never ☐ Former ☐ Current- Every Day ☐ Current- Some Days ☐ Smoker- Status Unknown ☐ Unknown

How Much_______________________________________ Years of use___________________________

Occupation_______________________________________ ☐ Full Time ☐ Part Time ☐ Modified Duty ☐ Disabled

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Live alone or with others ☐ Alone ☐ With Others Single or multilevel home ☐ Single ☐ Multilevel

Alcohol Intake ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Exercise Level ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Activities____

Shoe Size ______________ Are you a Student ☐ Yes- Full Time ☐ Yes- Part Time ☐ No

Caregiver ☐ Yes ☐ No If yes, name and number ____

Nursing Facility ☐ Yes ☐ No If yes, name and number____

Surgical History

Past Surgical History? ☐ Yes ☐ No If yes, please provide detail below Surgical History Attached ☐ Yes ☐ No

Date	Hospital	Physician	Medical Procedure

Past Medical History

No Past Medical History ☐

	Yes	Notes		Yes	Notes
Anxiety Disorder			HIV/AIDS		
Arthritis			High Cholesterol		
Asthma			Hypertension		
Bleeding Disorder			Kidney Disease		
Blood Clot (DVT's)			Leg or Foot Ulcer		
Cancer (Specify type & status in notes)			Liver Disease (Specify in notes)		
Claustrophobia			Lung Disease (Specify in notes)		
Coronary Artery Disease			Organ Transplant		
Diabetes (Specify in notes)			Osteoporosis		
Dialysis			Pacemaker		
Diverticulitis			Peripheral Neuropathy		
Fibromyalgia			Peripheral Vascular Disease		
Gout			Reflux Disease		
Heart Disease/Arrhythmia			Stroke		
Heart Attack (MI)			Tuberculosis		
Hepatitis			Urinary Tract Infections		
Hiatal Hernia			Other		

Financial Policy

Cancelled Appointments

This office requires a 24 hour notice if you are unable to keep your scheduled appointment. **(Initial_________)**

Insurance

Co-payments are due at the time of each visit and it is your responsibility to inform the office of the amount of your co-payment. If your co-payment is not made, you will be billed. The bill will include a $10.00 billing fee per statement. In order to file claims for you, it is required that you sign an assignment of benefits form for your insurance. We can set up your account to automatically charge your credit card for patient responsibility payments. You may be required to pay co-insurance, a deductible and a co-payment as determined by the medical coverage you have chosen for surgery, orthotics, and other services. These payments may be collected at the time of service. **(Initial_________)**

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plans to issue payment check(s) directly to Brian A. McDowell, CORP. for medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount covered by insurance.

Authorization to Release Information

I hereby authorize McDowell Orthopedics and Podiatry Group to (1) release any information necessary to insurance carriers regarding my illness and treatment (2) process insurance claims generated in the course of examination or treatment (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from McDowell Orthopedics and Podiatry Group on my behalf and/or the behalf of my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of the assignment is to be considered as valid as the original.

Acknowledgement of Privacy Practices

I acknowledge that I have been provided with a copy of the *Notice of Privacy Practices* containing a more complete description of the users and disclosures of my personal health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*.

- It tells me how the practice will use my personal health information for the purposes of my treatment, payment for me treatment, and healthcare options.
- The notice explains in more detail how the practice may use and share my personal health information for other than Treatment, Payment and healthcare Operations.
- The practice will also use and share my personal health information as required/permitted by law.
- I authorize to disclose my medication history to the practice.

Note: Uses and disclosure for TPO may be permitted with our prior consent in an emergency.

I understand that McDowell Orthopedics and Podiatry Group has the right to change the *Notice of Privacy Practices* and I may contact McDowell Orthopedics and Podiatry Group directly for a current copy of the *Notice of Privacy Practices.*

Disclosure of Personal Health Information

I authorize and give permission to disclose my personal health information to the following person(s) listed below:

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By signing this, I acknowledge the Assignment of Benefits Form, the Financial Policy, the Acknowledgment of Privacy Practices, and the Disclosure of Personal Health Information.

Printed Patient Name____________________________________ **Printed Signer Name**____________________________________

Signature of Patient, Parent, or Guardian____ **Date**________________________________

Relationship to Patient__________________________________ **Self** ☐