Synergy Orthopedic Specialists
medical group

PATIENT INFORMATION

Name: _____ DOB: _____/_____/_____
Last First initial

Sex: (____) M (____) F Social Security:_____-_____-_____ Marital Status: S / M / D / W

Mailing Address: _____
Street City ZIP

Phone #: _____ Cell #: _____

E-mail address: _____

Employer: _____Work phone: _____ Ext: _____

Emergency Contact: _____ Phone: _____

Pharmacy: _____ Phone: _____

Address: _____

Person Responsible for Bill: (____) Self (____) Spouse (____) Parent (____) Other: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Sex: (____) M (____) F DOB: ____/____/____ Social Security: _____-_____-_____

Primary Insurance: _____ Policy Number: _____ Group#: _____
Subscriber's Name: _____ Relationship: _____ DOB: _____/_____/_____

Secondary Insurance: _____ Policy Number: _____ Group#: _____

Subscriber's Name: _____ Relationship: _____ DOB: _____/_____/_____

Patient's Family Doctor: _____

HOW DID YOU HEAR ABOUT US? _____

Synergy Orthopedic Specialists
Medical Group, Inc.

Jay S. Berenter, DPM, FACFS
Jamey A. Allen, DPM, AACFAS

Scripps/XiMed Building
9850 Genesee Ave, Ste 510
La Jolla CA 92037

Office: (858) 450-9218
Fax: (858) 450-3296
www.drberenter.com
www.synergysmg.com

Medical History

Patient Name: _____ DOB: _____/_____/_____

What is your foot problem?

_____

_____

_____

When did the problem begin? _____ Date (if any injury) _____

Describe any accident/event: _____

Is this your first visit to a doctor for this problem? [ ] Yes [ ] No

Describe any previous treatment or home remedies: _____

Do you have or have you ever been treated for:

Diabetes	[ ] Yes [ ] No
HIV	[ ] Yes [ ] No
Heart Disease	[ ] Yes [ ] No
High Blood Pressure	[ ] Yes [ ] No
Poor Circulation	[ ] Yes [ ] No

List other health problems: _____

_____

_____

Allergies to injection, oral, or topical administration of:

Penicillin or other antibiotics?	[ ] Yes [ ] No
Narcotics? (Codeine, Vicodin)	[ ] Yes [ ] No
Local anesthetics?	[ ] Yes [ ] No
Adhesive tape?	[ ] Yes [ ] No
Latex?	[ ] Yes [ ] No
Any other drug or medication?	[ ] Yes [ ] No

Please list: _____

_____

_____

Please list your medications: _____

_____

_____

Are you slow to heal after cuts? [ ] Yes [ ] No

Any abnormal bruising or bleeding? [ ] Yes [ ] No

Height: ___'___" Weight: _____ Shoe size: _____

How much are you on your feet at work?

[ ] 20% [ ] 40% [ ] 60% [ ] 80% [ ] 100%

List any sports/activities: _____

_____

Do you smoke? [ ] Yes [ ] No

Do you drink alcoholic beverages?

[ ] None [ ] Rarely [ ] Moderately [ ] Daily [ ] Quit

Have you had your Flu shot? [ ] Yes [ ] No

Date of flu shot: _____

Have you had your tetanus shot? [ ] Yes [ ] No

If so, what year? _____

Please list previous medical or medical surgical problems: _____

_____

Have you been treated for this problem before? _____

If female, are you pregnant? [ ] Yes [ ] No

Have you ever had foot surgery before? [ ] Yes [ ] No When and by whom? _____

Have you had x-rays taken for this problem? [ ] Yes [ ] No When and by whom? _____

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NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

The Health Insurance Portability & Accountable Act of 1996 ("HIPPA") requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed.
We may use and disclose patient medical records only for the following purposes:

Treatment: Providing, coordinating, or managing health care and related services by one or more health care providers.

Payment: Activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)

Health care operations: Conducting quality assessment and improvement activities, auditing functions, cost-management analysis, custom services and as required by law.

We may create and distribute non-identified health information by removing all references to individually identifiable information.

We may contact patients to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services.

Any other uses and disclosures may be made only with patient's written authorization.
We have the right to change our Privacy practices from time to time. Patients may request a current copy by writing to address indicated above.

Patients have the following rights with respect to their protected health information.
Patients may exercise these rights by submitting a written request to address indicated above, attention Office Manager:

The right to request restring on certain uses and disclosures of protected health information, including those related to family members other relatives, close personal friends, or any other person identified by patient.
The right to reasonable request to receive confidential communications of protects health information from this organization by alternative means or locations.
The right to inspect and copy protected health information.
The right to amend protected health information.
The right to receive an accounting of disclosure of protected health information.
The right to request a paper copy of this notice.

I, hereby, acknowledge that I have been given the right to review this organization's Privacy Practice and give my consent to use my protected health information under the conditions provided.

_____ _____

Patient or guardian **Date**

You have my permission to leave messages for me on my home phone, cell phone, or e-mail

_____ _____

Patient or guardian **Date**

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ABOUT FINANCIAL ARRANGEMENT AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a part to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (Example: orthotics, post-op shoes, etc.).

We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help.

Due to the nature of the business in this office, there may be times when your insurance carrier will not reimburse for routine foot care, orthotics, and/or Durable Medical Equipment. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information above, and I certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or the above information. I authorize payment of medical benefits to the medical group named above.
I hereby give permission to the doctor to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition.

_____ _____

Patient or guardian **Date**

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Authorization to Release Health Information

Patient's Name: _____

Date of Birth: _____

My confidential healthcare information and/or billing information may be discussed with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient's signature Date

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