Center for Foot Surgery
Fax: (818) 475 – 1406

903 West 7th Street, Oxnard, CA 93030 I Phone: (805) 263 – 4090
18433 Roscoe Blvd, Suite 105, Northridge, CA 91325 I Phone: (747) 356 – 8242

Patient Information Form

Personal Information

Last Name: _____ First Name: _____ MI: ____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Date of birth: ___ / ___ / _____ Age: ___ Sex: ☐ Male ☐ Female
Address: _____ City: _____ State: ___ Zip: _____
Social Security: ___-___-_____ Email Address: _____
Home: (___) ____-_____ Cell Phone: (___) ____-_____ Work: (___) ____-_____
Spouse / Child Name: _____ Phone: (___) ____-_____
Race: _____ Ethnicity: _____ Language(s): _____

Treating Physicians

Referring Physician: _____ Primary Care Physician: _____
Other Physicians Providing Care: _____

Pharmacy

Name & Location Phone Fax

_____

Insurance Information

Primary Insurance: _____ ID Number: _____
Name of Insured: _____ Date of birth: ___ / ___ / _____
Relationship to Insured: _____

Secondary Insurance: _____ _____ ID Number: _____
Name of Insured: _____ Date of birth: ___ / ___ / _____
Relationship to Insured: _____

Emergency Contact

Name: _____ Relationship: _____
Address: _____ City: _____ State: ___ Zip: _____
Home: (___) ____-_____ Cell Phone: (___) ____-_____ Work: (___) ____-_____

I hereby consent to and authorize the performance of all treatments, surgery, and all medical services by the **Center for Foot Surgery and Ronald Belczyk DPM INC**. I accept full financial responsibility for all medical/ surgical services performed on my behalf that are not covered by my insurance company. **All co-payments, deductibles and non-covered services are due at the time of service**, unless prior arrangements have been made. I hereby authorize the provider and assistants to release all information necessary acquired in the course of my examination and/or treatment to secure payment for services. I hereby authorize my insurance company to pay benefit directly to the Center for Foot Surgery.

X_____ _____ _____
Patient or Guardian's Signature Patient or Guardian Name Printed Date

Medical History

Ambulatory Status: ☐ Walking ☐ With cane/walker ☐ Wheel Chair ☐ Stretcher

Chief Complaint History
Please describe the reason for your visit:
_____
_____

Date of injury/condition onset and duration: _____

Describe your symptoms: ☐ Pain ☐ Swelling ☐ Burning ☐ Tingling ☐ Numbness
☐ Pain at rest ☐ Pain with Activity ☐ Other Symptoms: _____

What treatments have you tried? ☐ Orthotics ☐ Medications ☐ Injections ☐ Physical Therapy
☐ Surgery ☐ None ☐ Other Treatments: _____

Health History
☐ Diabetes ☐ Hypertension ☐ Hyperlipidemia ☐ CVA/TIA
☐ Stress Test: ☐ No (☐ Yes: ☐ Normal ☐ Positive)
☐ Coronary Heart Disease: ☐ No ☐ Yes: (☐ Hx of MI ☐ Stable Angina ☐ Unstable Angina)
☐ Renal: ☐ No ☐ Yes ☐ Dialysis (circle) Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

Social History
Exercise: ☐ No ☐ Yes ___x/week
Pregnant: ☐ No ☐ Yes
Smoking: ☐ Never ☐ Current: ___#pack/day ☐ Prior: Quit date: _____
Alcohol: ☐ No ☐ Yes Drinks: ___#/day ___#/week

Family History
Mother: ☐ Alive ☐ Deceased Medical History: _____
Father: ☐ Alive ☐ Deceased Medical History: _____
Sibling(s): Medical History: _____

Medications	Dose	Frequency

Allergies
☐ Penicillin ☐ Sulfa ☐ Seafood ☐ Latex ☐ Topical Iodine/Betadine ☐ IV Contrast ☐ Adhesive/Tape
☐ Local Anesthetic ☐ Novocaine ☐ Lidocaine ☐ General Anesthesia ☐ Codeine ☐Anti-inflammatories
☐ Aspirin ☐ Others: _____

Surgical History

Surgical Procedure	Year	Surgeon or Hospital	Complications?

Review of Systems

Cardiac:

☐ Chest Pain/Tightness ☐ Atrial Fibrillation ☐ Heart Murmur ☐ Palpitation
☐ Pacemaker: ___Year ☐ Congestive Heart: (☐ Mild ☐ Moderate ☐ Severe)

Respiratory/Lungs:

☐ Cough/Sputum ☐ Painful Respiration ☐ Sleep Apnea ☐ Tuberculosis
☐ Shortness of Breath ☐ Blood in Sputum ☐ Asthma ☐ Emphysema
☐ COPD: (☐ On Meds ☐ On Oxygen ☐ Not treated)

Vascular:

☐ Cramps Walking ☐ Leg Pain (☐Right ☐Left) ☐Swelling (☐ Arms ☐ Legs)
☐ IVC Filter ___ Year ☐ Angioplasty for Legs ☐ Bypass surgery for legs ___ Year.
☐ Amputation: (☐ Below ☐ Above Knee) ☐ Change in Skin Color
☐ Vein stripping ☐ Poor Circulation ☐ Gangrene ☐ Blood Clots
☐ Foot ☐ Toes: (☐ Ulcer ☐ Infection) ☐ Numb/Tingling (☐ Arms ☐ Legs)
☐ History of Aneurysm ☐ Surgery for Neck Arteries

Endocrine:

☐ Diabetes Mellitus ☐ Hormone Replacement Therapy ☐ Thyroid Problems _____

Neurologic:

☐ Stroke ☐ Blurred Vision ☐ Multiple Sclerosis ☐ TIA ☐ Syncope ☐ Fainting ☐ Headache
☐ Dizziness ☐ Seizure

Genitourinary:

☐ Renal Failure ☐ Blood in urine ☐ Impotence ☐ Dialysis ☐ Nocturia ☐ Discharge
☐ Pain in Urination (Frequency: _____)

Gastro-Intestinal:

☐ Abdominal Pain ☐ Black Stools ☐ Constipation ☐ Poor Appetite ☐ Nausea/Vomiting
☐ Hepatitis A B C ☐ Weight Loss ☐ Diarrhea ☐ IBS

Hematologic/Oncologic:

☐ Tumor Growth / type: _____ ☐ Cancer Type _____/_____ Year.
☐ Chemotherapy ☐ Radiation Therapy ☐ Enlarged Lymph Notes ☐ Anemia ☐ HIV ☐ AIDS

Musculoskeletal:

☐ Back Pain ☐ Joint Replacement ☐ Neck Pain ☐ Joint Swelling ☐ Polymyalgia ☐ Arthritis

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Thank you for choosing the Center for Foot Surgery as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that you will be financially responsible for charges that are not covered by your insurance. If you have any questions regarding your financial account with our office, please contact us by phone at 747-263-9696, or email us at info@ronaldbelczykdpm.com.

PATIENT FINANCIAL RESPONSIBILITY

- We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered.
- If you do not provide us with the current insurance card or do not have insurance, full payment is due at the time of service. We accept cash, check, or credit card (Visa, MasterCard, Discover, or Amex).
- Please notify us immediately if there are any changes to your insurance plan or coverage.
- Co-payments and Deductibles are an agreement between you and your insurance plan and are your responsibility.
- Co-payments are due at the time of service and charges to cover your deductible may be requested to be paid toward if it has not been satisfied.
- Medical records or copies of records can be provided at your request; please allow up to 5 (five) business days for records to be compiled.
- There will be a $35.00 fee for all returned checks and credit payments.

SELF PAY - Full payment at the time of service is required unless prior arrangements have been made.

MEDICARE - We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

HMO/PPO - We are providers for many insurance plans, but not all plans. You are responsible for verifying if we are providers for your plan. If you are an HMO member, you must have a current referral at the time of your visit in order to be seen, and for the visit to be covered under your plan. Without a proper referral, you may be responsible for charges incurred. If you are a PPO member, you are responsible for co-payments, deductible, and co-insurance. Please confirm with your insurance that we are providers covered under your plan.

MISSED APPOINTMENT - You may be billed a $50.00 charge for missed appointments that are not canceled within 24 hours' notice.

HOSPITAL & SURGERY CENTER CHARGES - In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility.

UCR (USUAL & CUSTOMARY RATES) - We are committed to provide the best treatments possible for out patients. Our fees for services rendered are usual and customary for our geographic area. If we do not have a contract with your insurance company, you are responsible for your payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

PATIENT FINANCIAL POLICY AGREEMENT

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check or credit card. Past due balances may be subject to additional fees. I understand that if the office agrees to bill insurance as courtesy. I must submit information as needed in a timely manner, to ensure that payment for services is rendered. I understand that I am ultimately responsible for payment of all services.

X_____ _____ _____

Patient or Guardian's Signature | Patient or Guardian Name Printed | Date