RENEW
FOOT & ANKLE INSTITUTE

DREW ALLEN, D.P.M.
PODIATRIC MEDICINE & SURGERY

PATIENT INFORMATION FORM

DATE: ___/____/____ (PLEASE PRINT)

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO HEIGHT_____

WORK PHONE #: (____) ____-_____ YES NO WEIGHT_____

CELL PHONE #: (____) ____-_____ YES NO SHOE SIZE_____

E-MAIL: _____ YES NO

PREFERRED METHOD OF CONTACT ❒ HOME PHONE ❒ WORK PHONE ❒ CELL PHONE

PRIMARY LANGUAGE:_____RACE:_____ETHNICITY:_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____
PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) _____
_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

RENEW
FOOT & ANKLE INSTITUTE

DREW ALLEN, D.P.M.
PODIATRIC MEDICINE & SURGERY

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	NAME	DOSE

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ CANCER ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

RENEW
FOOT & ANKLE INSTITUTE

DREW ALLEN, D.P.M.
PODIATRIC MEDICINE & SURGERY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS (A,B,C)	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
AVERAGE BLOOD SUGAR			OTHER CONDITIONS:					

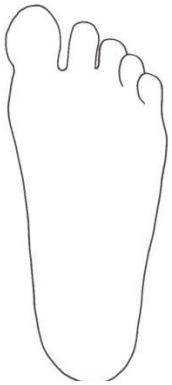
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

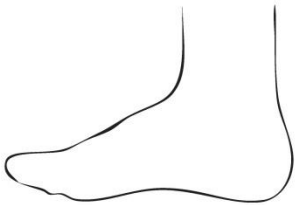
LEFT FOOT

TOP OF FOOT



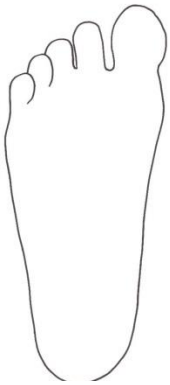
BOTTOM OF FOOT

INSIDE OF FOOT

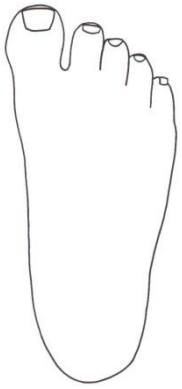


OUTSIDE OF FOOT

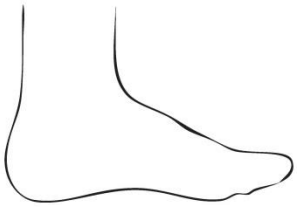
RIGHT FOOT



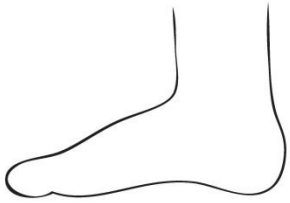
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED OVER TIME

TEL (562) 698–0381 • FAX (562) 696–2362 • 8032 South Painter Avenue, Whittier, CA 90602

RENEW
FOOT & ANKLE INSTITUTE

DREW ALLEN, D.P.M.
PODIATRIC MEDICINE & SURGERY

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS OR THE ABOVE INFORMATION.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

CONSENT TO TREAT

I request and authorize Drew Allen, DPM and his staff to provide me with treatment, and to perform any procedures now contemplated or such additional procedure as my doctor may deem reasonable and necessary.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept the terms. It is further understood that this release remains in effect for as long as I am patient of Dr. Drew Allen unless otherwise revoked.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

TEL (562) 698–0381 • FAX (562) 696–2362 • 8032 South Painter Avenue, Whittier, CA 90602

Patient focused foot care specializing in sports medicine and surgery

RENEW
FOOT & ANKLE INSTITUTE

DREW ALLEN, D.P.M.
PODIATRIC MEDICINE & SURGERY

PATIENT CONSENT FORM

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 been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 below to obtain a current copy of the *Notice of Privacy 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

HIPPA STATEMENT

I acknowledge that I was provided a copy of the *Notice of Privacy Practices* and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

RENEW
FOOT & ANKLE INSTITUTE

DREW ALLEN, D.P.M.
PODIATRIC MEDICINE & SURGERY

UNDERSTANDING YOUR INSURANCE RESPONSIBLITIES

We are pleased you have chosen Renew Foot and Ankle Institute to care for your foot problems. Our goal is to provide quality patient focused foot care.

The status of medical insurance in our country is changing rapidly with many new forms of coverage appearing yearly. Many patients change insurance policies and companies just as frequently. For these reasons and to prevent any "misunderstandings", it is important to understand what our mutual responsibilities are.

We will submit your medical claim based on the information provided to us by you and your insurance company. We do need your help in order to do this properly. We need a current copy of your insurance cards, the name and date of birth of the primary subscriber on the plan, and your date of birth and your marital status. We need to know if this is an individual or group plan provided by an employer. Please advise us prior to the date of service for proper insurance submission if you change plans. Otherwise, insurance benefits may be denied or delayed by your insurance company and therefore you immediately become financially responsible for the provided services.

We will help you determine your insurance coverage and benefits by contacting your insurance company whenever possible. However, in many instances, an insurance company will not advise or guarantee coverage and/or payment. Upon occasion some insurance companies do not provide accurate information.

Medical Conditions that existed prior to the commencement of your medical insurance may be considered a "pre-existing condition" and may not be eligible for coverage by your insurance company. You are responsible for advising us of any pre-existing conditions that may affect the coverage and benefits of your medical plan.

You need to be familiar with your policy's coverage, eligibility and benefits. Please be informed that deductibles, co-payments and or fees for non-coverage services, as determined by your insurance company, are your responsibility. Unpaid medical claims due to lapse or termination of coverage, delayed payments if incorrect information is provided also if the insurance company does not process the claim in a timely manner; will be your responsibility.

If you have a deductible and you have not met it yet, then you will be responsible to pay out of pocket until you have met your deductible. Only then will your insurance start paying for your covered benefits. If you have a co-pay, it is your responsibility to pay it at the time or your visit.

I have read and understand the above insurance policy and agree to proceed with the services. I also have read and understand my responsibility and am willing to pay any balance and fees on my account for the professional services rendered, regardless of my insurance status.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

ASSIGNMENT CONTACT INFORMATION

I, the undersigned certify that I (or my dependent) have insurance coverage with_____. And assigns to Dr. Drew Allen all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information, including information which may be considered a communicable.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

TEL (562) 698–0381 • FAX (562) 696–2362 • 8032 South Painter Avenue, Whittier, CA 90602