CANYON OAKS
FOOT & ANKLE

DR. DEREK J. FLOREK | DR. TYLER P. MAY

Thank you for selecting our office for your foot and ankle health care needs. We have prepared this packet of information and forms to help make your visit as convenient as possible. Prior to your appointment, please contact your insurance company to clarify your coverage requirements.

ABOUT REFERRALS

We accept most insurance plans. If you have an "HMO" plan rather than a "PPO" plan you must check with your insurance provider prior to your visit to determine whether a referral is needed. If a referral is required we will require that a printed referral is present at the time of the visit. If you are seen on your appointment day without a referral you may be responsible for cost of your office visit. These plans almost always will require a referral prior to visiting a specialist.

WHAT TO BRING

Completed healthcare questionnaire

- Completed personal / insurance information
- Insurance card
- Referral if required by your insurance
- Any previous pertinent medical records and/or x-rays
- Representative pair of shoes that you wear
- Any previous orthotic or healthcare aids that may be pertinent to your care

OFFICE VISIT PAYMENT

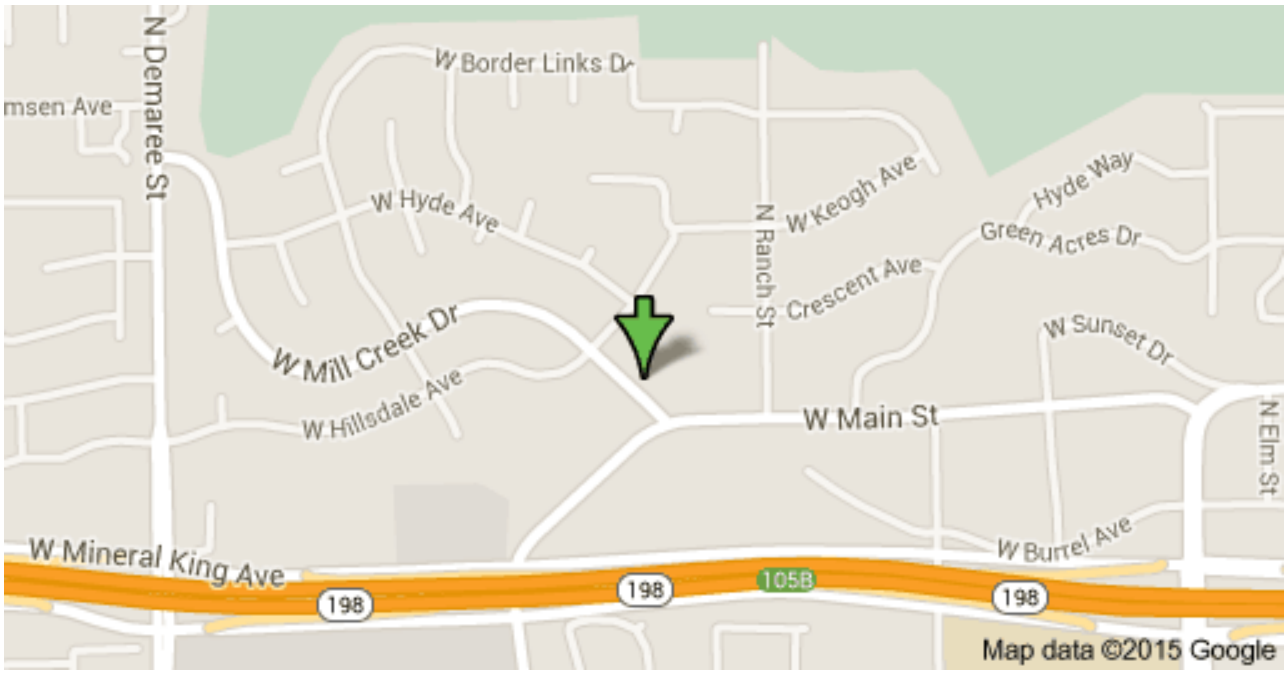
(You will be required to pay the following as applicable at the time of the visit)

- Insurance Co-payment
- Amount of office charges if your deductible has not been reached
- The cost of the entire office visit if you do not have insurance.

We accept all forms of payment including VISA and debit cards. We do charge for missed visits if less than 24hr notice of cancellation is not received.

DIRECTIONS

We are located just 2 blocks West of Main Street and Mooney Blvd (Hwy 198/63 South), just east of Demaree Street. Main Street is behind the Sheriff's office – Court House and Tulare County Buildings (on Mineral King/Mooney)



PATIENT REGISTRATION FORM Today's Date: _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)					
Last Name:		First Name:		Middle Initial:	
Address:		City		State	Zip
Home Phone:	Work Phone:	Cell Phone:	Email:		
Social Security:		Date of Birth	Age	Sex ☐Male ☐Female	Marital Status:
Employer Name:	Address:			Work Phone	
Emergency Contact Name:			Emergency Contact's Phone:		
Please tell us how you heard about us:			Referred by:		
GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames) Relationship of Guarantor to Patient: ☐Self ☐ Spouse ☐Parent ☐Guardian ☐Other					
Last Name:		First Name:		Middle Initial:	
Address:		City:		State:	Zip:
Social Security:				Date of Birth:	
Employer:		Work Phone:			
Address:		City:		State:	Zip
INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards) REQUIRED FIELDS- PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS. Please read and sign back of form.					
PRIMARY INSURANCE:			Insured's Name:		
Insured's Social Security	Insured's D.O.B:	Policy / ID Group:		Effective:	
Claims Address & Phone:					
SECONDARY INSURANCE:			Insured's Name:		
Insured's Social Security:	Insured's D.O.B:	Policy / ID Group:		Effective:	
Claims Address & Phone:					

HEALTH CARE PROVIDER INFORMATION

Primary Care Provider:		Phone:
Cardiologist (if any):		Phone:
Preferred Pharmacy:	Location:	Phone:

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

Patient's Name	D.O.B	First Name (Parents if under 18)	Last Name

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to Flaherty & Florek Foot Care, Inc. or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Flaherty & Florek Foot Care is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID INSURANCE BENEFITS: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Flaherty & Florek Foot Care, Inc. or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have received and read a copy of the Flaherty & Florek Foot Care, Inc. Patient Information Privacy Policy. I hereby Flaherty & Florek Foot Care, Inc. or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a CANYON OAKS FOOT & ANKLE, Inc. representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Flaherty & Florek Foot Care, Inc. to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES: I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my CANYON OAKS FOOT & ANKLE physician or his or her designee.

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HIPAA ACKNOWLEDGMENT RECEIPT I have received a copy of the HIPAA privacy policy and I understand that it is my responsibility to read and understand the policy. Flaherty & Florek Foot Care will make every effort to comply with HIPAA rules and regulations and take the utmost care in securing the privacy of each and every patient.

PATIENT SIGNATURE: _____DATE: _____

GUARANTOR SIGNATURE: _____DATE: _____

(If different from patient) GUARANTOR NAME (Please Print):

_____

GENERAL INFORMATION

DATE: ___/___/___ Patient Name: _____ DOB___/___/___

CHIEF COMPLAINT (Nature of your Foot Pain or Problem):

_____

GENERAL HEALTH (If you have had or have any of the following, check all that apply):

Do you smoke?	□Yes	□No	□Never	Chewing Tobacco?	□Yes	□No	□Never
Do you drink?	□Yes	□No	□Never	How often do you drink?	□Daily	□2-3 Times/Week	
History of drug use?	□ Yes	□No	□Never		□Seldom (Less than 1 Time/ Month)		

Past surgeries or hospitalizations: Please use an extra sheet, if needed.

Year	List the Type of Surgery or Reason for Hospitalization:
Pacemaker: □Yes □No	Metal Implants: □Yes □No

Medications: Please use an extra sheet, if needed.

Name of Medication:	Mg (Dose)	How Often:

ALLERGIES Are you allergic or sensitive to:

□ Penicillin □ Novocain □ Anesthetics □ Adhesive Tape
□ Iodine □ Metal □ No known Allergies
□ Other: _____

FAMILY HEALTH Have you or any of your family members ever had any of the following (please check all that apply)

You	Family		You	Family	
□	□	Anemia	□	□	High Blood Pressure
□	□	Arthritis/Rheumatoid	□	□	HIV
□	□	Asthma	□	□	Kidney disease/Dialysis
□	□	Blood Disorders	□	□	Liver Problems
□	□	Blood vessel disease	□	□	Lung disease
□	□	Cancer	□	□	Lupus
□	□	Dementia	□	□	Nerve Disorder/Neuropathy
□	□	Diabetes	□	□	Osteoporosis
□	□	Epilepsy	□	□	Rheumatic fever
□	□	Heart Trouble	□	□	Thyroid Disorder
□	□	Hepatitis	□	□	Parkinson's

□ Other: _____

SYSTEM REVIEW CHECK LIST PATIENT NAME:_____

Do you currently have any of these symptoms?

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□ Yellow eyes or skin

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Heat or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

Office Use Only:

B/P: _____ Pulse: _____ Temp: _____ Blood Sugar: _____

Weight: _____ Shoe Size _____