Welcome to Our Office (6-23-15)

[ ] Update

Whom may we thank for referring you to us? ____

Patient's Name ________________________________ Gender: M___ F___ Age ______

Address ____

Street city zip code

Marital Status __S __M __D __W Date of Birth____________ Home Phone_________________

E-Mail Address ____________________________ Mobile phone ______________________

Social Security # ____________________________ Drivers License # ___________________

Employed by ____________________________ Occupation ________________________

Address ____________________________ Business phone ______________________

( ) Ins. Subscriber Name: _____________________Relationship to Patient____________________

( ) Subscriber SSN# ____________________________ Subscriber Date of Birth ____-_____-____

Primary Insurance ____________________________ Second Insurance___________________

Employed by ____________________________ Occupation ____________________

City ____________________________ Business Phone ________________

Person responsible for payments not made by insurance __________________________________

Primary physician ____________________________ Phone _____________________________

Address ____________________________ City/Zip ____________________________

Reason for visit ____

Is this a work injury? **Y N** Sport injury? **Y N** Other injury? **Y N**

When did this occur or begin?__________________ Now is it: worse / better / the same

Other doctors seen for this problem?______________________________ When? ______________

Do or did you wear shoe inserts? **Y N** Are they from a doctor? **Y N**

Any X-rays or Scans? ___________ Prior treatments ______________________________________

What regular exercise or sports do you do? _________________________ How often? __________

During the day are you: mainly sitting / half sitting, half on you feet / mainly standing or walking

Are you working your usual or full time hours? **Y N** Are you doing your usual work? **Y N**

Steven N. Klein DPM, ABPS
139 Arch St., Suite # 1
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Phone (650) 366-3668
Fax (650) 366-7209

OUR OFFICE POLICY (5-05)

Welcome. Dr. Steven Klein and staff are looking forward to providing you the highest quality Podiatric care. If you have insurance we will submit a claim for our services. However, please understand our payment policy:

By signing below you agree and understand that is your responsibility to fully comprehend the benefits package provided by your insurance company. If the services rendered are determined to be unauthorized, not covered for any reason, denied, unpaid or coverage is terminated prior to the visit, you accept full financial responsibility.

Co-payments, deductibles and payment for non-covered supplies or services are your responsibility and are due at the time of each visit. Supplies, foot orthotics and braces or splints may not be covered expenses. Much insurance pay only a percentage of the covered fee and the remainder will be your responsibility.

A monthly $5.00 rebilling fee will be applied to your balance when insurance reimbursement is not received within 60 days or a personal payment within 30 days.

I authorize my health insurance benefits to be paid directly to Dr. Steven N. Klein.

_______ (Please initial)

I authorize Dr. Steven N. Klein to release my medical records to my insurance company or to other physicians. And I authorize Dr. Steven N. Klein to obtain my medical records, x-rays, and other medical information from other physicians or medical facilities.

________ (Please initial)

I acknowledge that I have had access to the Privacy Policy Statement regarding Protected Health Information as posted. Upon my request I will be given a copy of the statement.

_________ (Please initial)

My portion of today's charges, if any, will be paid by: (please check one)

( ) CASH ( ) CHECK* ( ) VISA ( ) MASTERCARD

There is a $ 20.00 charge for personal checks returned by the bank.

Print Name ______________ Signature ______________ Date ______________

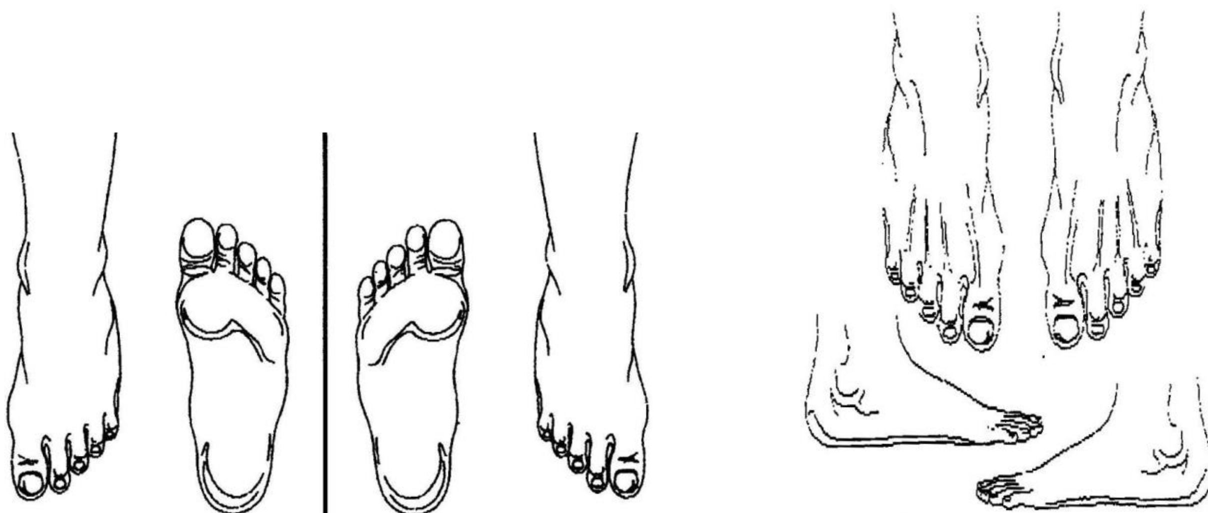
Symptom Survey (11-15)

Patient Name ____ Date _____________________

DO YOU HAVE FOOT, ANKLE OR LEG PAIN: ___ YES ___NO

Where is your pain?

Draw "Xs" on the diagrams where your problem is located.



LEFT RIGHT RIGHT LEFT

Circle the number for your pain 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10
No pain Worst pain possible

Since your last visit is your pain BETTER WORSE SAME DIFFERENT

I can walk with no pain for _______ minutes / hours.
I feel pain but I can still tolerate walking for up to_______ minutes / hours.
****

My pain occurs:
Check as many as apply

- **( ) When I first get out of bed or a chair.**
- **( ) During the daytime, pain comes and goes; NOT all day.**
- **( ) During or after prolonged standing or walking.**
- **( ) During or after sports, exercise or running.**
- **( ) Almost all day: Feels the same whether sitting, standing or walking.**
- **( ) Mostly sitting or in bed or during the night.**
- **( ) Other: ____**

My WORST pain is when I ____

My LEAST pain is when I ____

My AT REST (in a chair or bed) my pain is: ( ) Gone or Mostly Gone ( ) Same / Unchanged ( ) Worse

What does the pain keep you from doing? ____

My main concerns or questions are:

1. ____

2.____

MEDICAL HISTORY

6-23-15

NAME:________________________________ HEIGHT________ WEIGHT__________ DATE_________________

Is your current health: GOOD _________ FAIR__________ POOR__________ SHOE SIZE____________

Do you NOW, or have your EVER had any of the following?

Condition		What Years?	Condition		What Years?
Diabetes	YES NO	____________	Rheumatic Heart Disease	YES NO	____________
High Blood Pressure	YES NO	____________	UNusual Childhood Disease	YES NO	____________
Heart Attack	YES NO	____________	Recent Infections	YES NO	____________
Heart Condition	YES NO	____________	Arthritis	YES NO	____________
Angina	YES NO	____________	Gout	YES NO	____________
Stroke	YES NO	____________	Clotting Problems	YES NO	____________
Asthma: last attack -	YES NO	____________	Bleeding Problems	YES NO	____________
Emphysema / Pneumonia	YES NO	____________	Phlebitis: Rt Lt leg	YES NO	____________
Hepatitis, Type: A B C	YES NO	____________	Anemia:( )low iron ( )other	YES NO	____________
Kidney / Bladder Infection	YES NO	____________	Stomach Ulcers	YES NO	____________
Venereal Disease	YES NO	____________	Intestinal Problems	YES NO	____________
Cancer: Type / Organ	YES NO	____________	Seizures	YES NO	____________
Gland Condition (thyroid, etc.)	YES NO	____________	Tested for Aids	YES NO	____________
WOMEN: Are you Pregnant?	YES NO	____________	On Dialysis	YES NO	____________

Other:____

Please list ALL Medications you are currently taking:

MEDICATION:	CONDITION USED FOR:	DOSE:	DOCTOR:
1			
2			
3			
4			
5			

____I HAVE NO ALLERGIES TO MEDICATIONS, or Check if you EVER had an ALLERGIC reaction to:

____Penicillin

____Codeine

____Local Anesthetics (Novacaine)

____Aspirin

____Sulfa Drugs

____Other ________________________________

Have you EVER used: TOBACCO? Yes No How much_________ When _____________

ALCOHOL? Yes No How much____________ When________________

TOE, FOOT OR ANKLE SURGERIES: ____ NONE

Procedure ____ Date ______________ DR. _____________

____ Date ______________ DR. _____________

____ Date ______________ DR. _____________

OTHER SURGERIES: ____ NONE

Procedure ____ Date ______________ DR. _____________

____ Date ______________ DR. _____________

____ Date ______________ DR. _____________

____ Date ______________ DR. _____________

SERIOUS INJURIES / FRACTURES: ____ NONE

Body Part ____________________ Injury ____________________ Date ______________ DR. _____________

____________________ Injury ____________________ Date ______________ DR. _____________

____________________ Injury ____________________ Date ______________ DR. _____________

HOSPITALIZATIONS (except for above): ____ NONE

For ____ Dates ______________ to ______________

____ Dates ______________ to ______________

____ Dates ______________ to ______________

Patient Name _________________ Date of Injury _____-_____-_____

Worker's Compensation History of Treatment

(4-04)

Date you 1st had lower extremity or foot pain: _____-_____-_____

Date you 1st received medical care or saw a doctor for this problem: _____-_____-_____

Dr.'s Name _______________________

Dr.'s Diagnosis _______________________

Did this doctor get X-rays? ( ) No ( ) Yes, and they showed: _______________________________

This doctor's treatments were: [check all that apply]

( ) medications (still taking, or stopped – circle the ones you are still taking):

____

( ) injection(s), how many _________

( ) shoe inserts ___custom made orthotics ___ over-the-counter insoles, pads or cushions

( ) cast or brace, for ____ weeks. Still use? ( ) No ( ) Yes

( ) physical therapy, started on _____-_____-_____, for ____ visits.

( ) surgery, date _____-_____-_____

Did this doctor ordered: [check all that apply]

( ) MRI ( ) CT scan ( ) Bone Scan ( ) Nerve Test – EMG / NCV ( ) Blood Test

Test / Scan showed:____

Did you see any other doctors for this problem? ( ) No ( ) Yes, Dr.'s name ____________________________

If yes, dates from _____-_____-_____ to _____-_____-_____. Still seeing? ( ) No ( ) Yes

If yes, did this doctor give a new or different diagnosis? ( ) No ( ) Yes, it was _____________________

If yes, did this doctor order any other or repeat tests? ( ) No ( ) Yes, they were __________________

If yes, did this doctor treat you? ( ) No ( ) Yes, with ____

Are you now seeing a different or new doctor for this problem? ( ) No ( ) Yes, Dr.'s name _________________

Date last seen _____-_____-_____

Next appointment_____-_____-_____

WORKERS COMPENSATION – JOB HISTORY & DESCRIPTION rev.8/00

Name: ________________________ Today's Date________________

FOR THE WORK WHERE YOU WERE INJURED:

Employer: __________________ Job Title: ____

Date of Injury: ____-____-____ Job Duties: ____

Hire Date: ____-____-____ ____

Last Date Worked at this Position: ____-____-____. Usual Hours Worked: per Day _____

Last Date Worked for this Employer: ____-____-____. Per Week _____

Work Activity: ( ) For the work where you were injured.
( ) If the is a re-evaluation, fill out this form for work duties **after** your injury.

Activity (hours per day)	**Never** 0 hours	**Occasionally** up to 3 hours	**Frequently** 3 – 6 hours	**Constantly** 6 – 8+ hours
Sitting				
Standing				
Walking				
Climbing				
Bending				
Squatting				
Kneeling				
Crawling				

	Usual Daily Carrying				**Usual Daily Lifting**			
	Never 0 hours	**Occasionally** up to 3 hours	**Frequently** 3–6 hours	**Constantly** 6–8+ hours	**Never** 0 hours	**Occasionally** up to 3 hours	**Frequently** 3–6 hours	**Constantly** 6–8+ hours
1-10 lbs.								
11-25lbs.								
26-50lbs.								
51-75lbs.								
76-100lbs.								
100+ lbs.								

Describe the heaviest item required to carry and the distance to be carried: ________________________________
____

Indicate if your job requires:

	YES	NO	If Yes, briefly describe
Working around equipment and machinery?	___	___	________________________
Walking on uneven ground?	___	___	________________________
Operation of foot controls or repetitive foot motions?	___	___	________________________
Steel-toed work boots or other special shoe gear?	___	___	________________________
Driving cars, trucks, forklifts and other machinery?	___	___	________________________

What is your usual footwear at work? __________________________ Is it mandatory? Y___ N____

Name: _________________________ Date of Injury: ____ - ____ - ____

Have you had work restrictions ordered by a Doctor? Yes___ No___ When________________________

Dr.'s Name ______________ How restricted? ____

Work History Since Injured:

Did you miss any work due to your injury? ………………………………………………….. Y _____ N_____

If Yes, what was the first date off work due to your injury?………………………………………____-____-____.

If yes, did you return to work?

( ) No, I have not returned to work.
( ) Yes, I returned to work on………………………………………………………………____-____-____
( ) If yes, did you return to the:
( ) Same employer and same job, usual work…………………Date restarted: ____-____-____
( ) Same employer, modified work*……………………………. Date restarted: ____-____-____
( ) Same employer, different work*……………………………..Date started: ____-____-____
( ) A new employer*………………………………………………Date started: ____-____-____
Employer: _____________________
Address: ____

*Describe NEW job duties, especially how it differs from type of job duties when injured:

____

____

Do you still have this job? ………………………………………………………………………..Y ____ N ____

If No, what was the last date you worked this job?………………………………………………..____-____-____

Your CURRENT WORK situation:

( ) Still off work, since Date: ____-____-____

( ) Same job/employer, usual work. Date restarted: ____-____-____

( ) Same employer, modified work*. Date restarted: ____-____-____

( ) Same employer, different work*. Date started: ____-____-____

( ) A new employer*. Date started: ____-____-____
Employer: _____________________
Address: ____

*Describe NEW job duties, especially how it differs from type of job duties when injured:

____

____

Second Job - Work History

Did you have a second Job when you were injured?……………………………………………Y ____ N ___ _

If yes, date started:……………………………………………………………………….____-____-____
Employer: _____________________
Address: ____

Job Duties: ____

____

Do you NOW have a Second Job? (at same time as your current job)…………………………..Y ____ N ____

If yes, date started:………………………………………………………………………. ____-____-____
Employer: _____________________
Address: ____

Job Duties: ____

____

Previous Jobs before your work injury: (most recent former employer first)

1. _______________________ Dates ___-___-___ to ___-___-___

Job Description: ____

2. _______________________ Dates ___-___-___ to ___-___-___

Job Description: ____

Signature ______________________________ Date_____________________