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
Redwood City, CA 94062
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

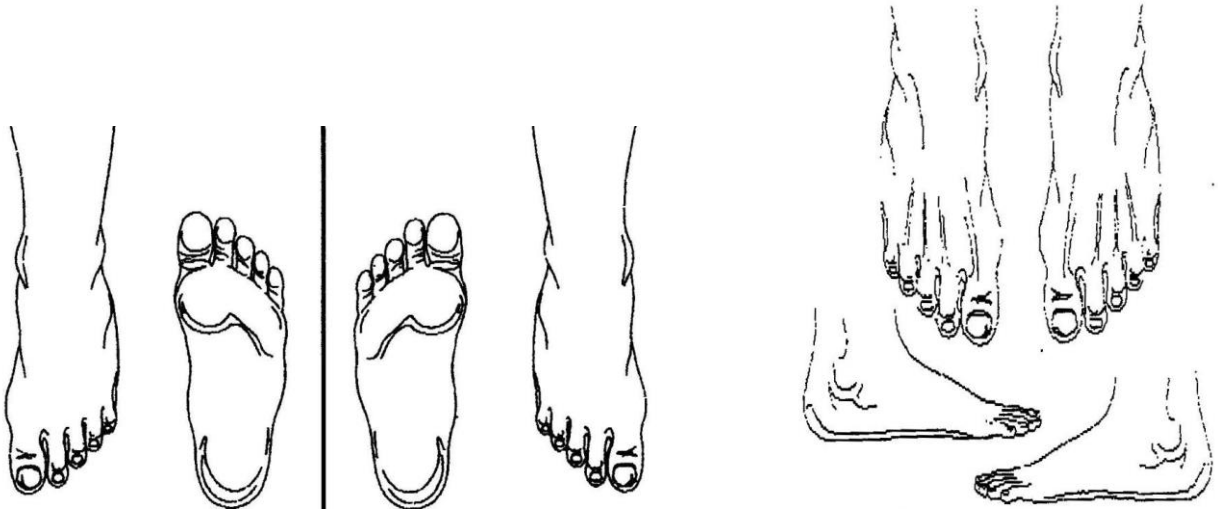
Symptom Survey (11-15)

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; <u>NOT</u> 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

7/19

NAME: _____ **HEIGHT** _____ **WEIGHT** _____ **DATE** _____

Is your health: **GOOD** _____ **FAIR** _____ **POOR** _____ **SHOE SIZE** _____

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

		WHAT YEARS?			WHAT YEARS?
Diabetes:	YES NO		Rheumatic Heart Disease	YES NO	
High Blood Pressure	YES NO		UNusual Childhood Disease	YES NO	
Heart Attack / Angina	YES NO		Recent Infections	YES NO	
Heart Condition:	YES NO		Arthritis	YES NO	
Stroke	YES NO		Gout:	YES NO	
Asthma:	YES NO		Clotting/Bleeding Problems	YES NO	
Bronchitis	YES NO		Anemia:( )low iron, ( )other	YES NO	
Emphysema	YES NO		Phlebitis: Rt Lt leg	YES NO	
Hepatitis, Type: A B C	YES NO		Stomach Ulcers	YES NO	
Kidney / Bladder Infection	YES NO		Intestinal Problems	YES NO	
Venereal Disease:	YES NO		Seizures	YES NO	
Pneumonia	YES NO		Tested for(Aids	YES NO	
Gland Condition: (thyroid)	YES NO		Cancer: _____	YES NO	
WOMEN: Are you Pregnant?	YES NO Due _____		Other: _____		

Please list ALL Medications you are currently taking:

____ **I TAKE NO MEDICATIONS** **( ) See List**

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

( ) Continued on back of this page.

____**I Have NO Allergies To Medications, or**

Check if you EVER had an ALLERGIC reaction to:

____**Penicillin ( ) rash ( ) breathing trouble**

____**Codeine ( ) nausea /vomiting**

____**Local Anesthetics (Novacaine)**

____**Aspirin ( ) acid stomach**

____**Sulfa Drugs ( ) rash ( ) breathing trouble**

____**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.** _____

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** _____

LEAVE BLANK:

Vital Signs: BP ___/___ P ____ Resp ____ Temp ____^{o}F Diabetics: FBS / finger stick _____ mg%