New Patient Form

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Last Visit w/PCP: _____

Endocrinologist: _____Last Visit w/Endo: _____Referred By: _____

Please describe your problem (include date of injury if applicable): _____

_____

_____

_____

PAST MEDICAL HISTORY

Check all that apply:

	Frequent Headache/Migraine		Anemia / Blood Disorders
	Rheumatic Fever		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis MWF or T TH Sa		Epilepsy / Seizures
	Diabetes Average Blood Sugar:		Prolonged Bleeding Time
	Tuberculosis		Stomach Disorder
	Emphysema		Thyroid / Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems / Tension
	BLOOD CLOTS		Asthma / Hay Fever / Shortness of Breath
	Tumor / Abnormal Growth / Cancer		Prostate Disorder
	Ear / Nose / Throat Disorder		Sexually Transmitted Disease

Has any FAMILY MEMBER had any of the following problems (Please indicate relationship):

Cancer: _____ Diabetes: _____ Heart Trouble: _____

High Blood Pressure: _____ Kidney Disease: _____ Stroke: _____

Mental or Emotional Disease: _____ Tuberculosis: _____

Arthritis: _____ Emphysema: _____ BLOOD CLOTS: _____

PATIENT INFORMATION

Do you currently smoke? ____ No ___ Yes If yes, how many packs /day? _____ How many years? _____

Smoke previously? ____ No ___ Yes If yes, how many packs/day? _____ How many years? ____ Year Quit: _____

Number of caffeine drinks per day: _____ Amount of alcohol consumed per week? _____

Please complete the following:

Height: _____ Weight: _____ Shoe Size: _____ Occupation: _____

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Other:_____

Exercise Type/Duration/ Frequency (Example: Walk 10 minutes 3X per week):_____

_____

New Patient Form

ALLERGIES

Please check all allergies:

___Medications: _____

___Foods: _____

___Tapes ___Novocain ___Anesthetics ___Silver/Nickel/Costume Jewelry ___Other:_____

What types of reactions have you experienced? _____

_____

MEDICATIONS

Please list all prescription and over-the-counter medications and the dosages: _____

_____

_____

_____

_____

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

HEALTH REVIEW

Please circle any symptoms you have had in the past 3 months:	
General	Fever Chills Fatigue Weight Loss Weight Gain
Head	Headaches Visual Problems Hearing Problems Light Sensitivity
Cardiovascular	Chest Pain Palpitations Dizziness Swelling of Legs Other
Hematology	Anemia Abnormal Bleeding/Bruising Blood Clots Other Blood Disorder
Respiratory	Persistent Cough Wheezing Shortness of Breath
Gastrointestinal	Difficulty Swallowing Indigestion/Heartburn Abdominal Pain Change in Bowel Habits
Urinary	Painful Urination Frequent Night-time Urination Bladder Leakage Other
Musculoskeletal	Join Pain/Swelling/Stiffness Back Pain Arthritis Muscle Weakness
Skin	Skin Rash Suspicious Lesions Itching
Neurological	Numbness of hands/feet Seizures Tremors Paralysis
Psychiatric	Depression Anxiety Problems Sleeping Memory Loss
Endocrine	Heat/Cold Intolerance Hot Flashes Change in hair/skin texture Other

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail, or phone by either physician or hospital. Also, I hereby authorize the doctor or her assistants to initiate the diagnosis and treatment of my condition with x-ray, examination, or photographs of infections as necessary.

Patient Signature: _____ Date: _____

I have personally reviewed the above information:

Physician Signature: _____ Date: _____

REGISTRATION
(PLEASE PRINT)

Phyllis A. Weinstein , DPM
Podiatrist
9822 Las Tunas Drive
Temple City,Ca 91780
Telephone:(626)285-7322

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ [redacted] _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

1. Primary Language:

_____

2. Race:

( ) American Indian or Alaska Native

( ) Asian

( ) Black or African American

( ) Native Hawaiian or Pacific Islander

( ) White

3. Ethnicity:

( ) Caucasian

( ) Hispanic/Latino

( ) Not Hispanic/Latino

Phyllis A. Weinstein, D.P.M., Inc.
9822 Las Tunas Dr.
Temple City, CA 91780

SIGNATURE ON FILE

Please check all and sign at the bottom.

( ) I authorize use of this form on all my insurance submissions.

( ) I authorize release of information to all my Insurance companies.

( ) I understand that I am responsible for my bill.

( ) I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.

( ) I authorize payment directly to my doctor.

( ) I permit a copy of this authorization to be used in place of the original.

Name: _____ Date: _____

Signature:

_____

Phyllis A. Weinstein, D.P.M., Inc.

9822 Las Tunas Dr.
Temple City, CA 91780
626-285-7322

Acknowledgement of Receipt of Privacy Practice Notice

I have been presented with a copy of Dr. Phyllis A. Weinstein, D.P.M., Inc., Notice of Privacy Practice Policy, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

_____

Further I permit a copy of this authorization to be used in place if the original and I request payment of medical insurance benefits either to myself or to the party of who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse, caretaker)

Relationship: _____ **Witnessed by:** _____

Internal Use Only:

If patient or patient representative refuses to sign acknowledgement of receipt notice please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____