PAULINE FU, DPM, PC

☐ **DR. PAULINE FU, DPM** ☐ **DR. LAUREL YEE, DPM**

PATIENT REGISTRATION SHEET

PATIENT'S NAME: _____ DATE OF BIRTH: _____

SEX: Male _____ Female _____Others (please specify) _____ SS#: _____-_____-_____

CELL PHONE_____ HOME PHONE: _____

EMAIL: _____

(We will send appointment reminders by email, text, and voice unless you notify us otherwise)

ADDRESS: _____ Apt #_____CITY:_____ STATE: _____ ZIP CODE: _____

MARITAL STATUS: Single: ____ Married:____ Divorced: ____ Widowed:_____

PRIMARY INSURANCE:_____POLICY NUMBER:_____

PRIMARY HOLDER NAME: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE:_____ POLICY NUMBER:_____

PRIMARY CARE PHYSICIAN: _____DATE LAST SEEN: _____

ADDRESS:_____PHONE: _____

PREFERRED PHARMACY: _____ADDRESS & PHONE:_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ *PHONE: _____

PATIENT/GUARDIAN OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____ BUSINESS PHONE: _____

HOW DID YOU HEAR ABOUT THE PRACTICE (CIRCLE ONE): INTERNET/GOOGLE/FRIEND/FAMILY/FACEBOOK/

INSURANCE/DOCTOR REFERRAL (WHICH DOCTOR?)_____

BRIEFLY DESCRIBE REASON FOR YOUR VISIT/COMPLAINT: _____

_____

***PAIN SCALE 1-10 (1 minor – 10 severe): _____**

PAST MEDICAL HISTORY: ***Height: _____ Weight: _____**

Do you or have you ever had any of the following?

_ Asthma	_ Heart problems	_ Psoriasis/Eczema	_ Rheumatic Disease
_ Arthritis	_ Kidney problems	_ Phlebitis	_ Venereal Disease
_ Anemia	_ Stroke (date:_____)	_ Venous insufficiency	_ Poor circulation
_ Bleeding problems	_ High Cholesterol	_ Stomach problems	_ Thyroid problems
_ Cancer (Type_____)	_ High Blood Pressure	_ Broken Bones	
_ Emotional problems	_ Hepatitis	_ Skin ulcers	
_ Emphysema	_ HIV	_None Apply	

_ Diabetes (How long?) _____ HbA1C and date: _____ This morning's glucose level:_____

Any other health problems? _____

ALLERGY:

Medications Y / N What medications_____ Reaction_____

Foods Y / N What Foods_____ Reaction_____

Latex Y / N Reaction_____

MEDICATIONS:

Medication Name	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGICAL HISTORY:

TYPE: _____ DATE:_____

TYPE: _____ DATE:_____

TYPE: _____ DATE:_____

FAMILY MEDICAL HISTORY AND WHO: _____

_____

SOCIAL HISTORY:

Alcohol Use Y / N Type_____ Quantity_____ Frequency_____

Tobacco Use Y / N Amount_____ Duration_____ Quit Date_____

Drug Use Y / N Amount_____ Duration_____ Quit Date_____

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Last Name_____ **First Name**_____ **DOB**_____

Review of Systems

Have you recently had any of the following?

General			**Cardiovascular**			**Genitourinary**		
Fever	Y	N	Chest Pain	Y	N	Blood in Urine	Y	N
Chills	Y	N	Palpitations	Y	N	Pain with Urination	Y	N
Nausea	Y	N	Shortness of breath on exertion	Y	N	Nighttime Urination	Y	N
Vomiting	Y	N	Heart Attack	Y	N	Recent UTI	Y	N
Night Sweats	Y	N	Stroke	Y	N	Frequent Urination	Y	N
Weight Loss Amt_____						Urine Retention	Y	N
Weight Gain Amt_____			**Blood**					
			Anemia	Y	N	**Musculoskeletal**		
Neurologic			Bleeding	Y	N	Joint Pain	Y	N
Seizure	Y	N	Bruising	Y	N	Joint Swelling	Y	N
Migraines	Y	N	Blood Clots	Y	N	Osteoarthritis	Y	N
Dizziness	Y	N	Transfusions	Y	N	Rheumatoid Arthritis	Y	N
Foot and ankle numbness	Y	N						
			Gastrointestinal			**Psychiatric**		
Skin			Abdominal Pain	Y	N	Anxiety	Y	N
Lumps	Y	N	Heart Burn	Y	N	Depression	Y	N
Rashes	Y	N	Indigestion	Y	N	Memory Loss	Y	N
Lesions	Y	N	Constipation	Y	N			
Itchiness	Y	N	Diarrhea	Y	N			
			Food Intolerance	Y	N			
Pulmonary			Pain with Swallowing	Y	N			
Shortness of Breath	Y	N						
Cough	Y	N						
History of TB/ +PPD	Y	N						

Patient/Guardian Signature_____ **Date**_____

Office Use Only:

Provider Signature_____ ***Date***_____

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Financial Agreement and patient's Responsibility

I_____have requested treatment from **Dr. Pauline Fu and/or Dr. Laurel Yee**, I have read and understand the following:

1. **I authorize the Provider who rendered the services and all insurers and carriers to furnish any further information required.**
2. **I authorize payment of Plan Medical Benefits directly to the named Provider of Service.**
3. **I am responsible for all co-payments, deductibles, and co-insurance as per the terms or any contract with my insurance carrier. All co-payments must be paid at the time of service.** This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e. for injections or x-rays.)
4. **Deductibles are the patient's responsibilities as set forth by your insurance carrier**. We reserve the right to collect any outstanding deductible during the time of your visit.
5. **I am responsible for obtaining any and all required referral for service.** Any services performed without referrals are considered out of pocket medical expenses.
6. **I am responsible for all non-covered services.** The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are determined by my insurance carrier.
7. **I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins.** The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
8. **The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion so that the claim may be paid.** Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.
9. **Fees associated with orthotic casting prepared at my request, are my responsibility.** Should I choose to stop the process of making the orthotics after casting occurred, I am still responsible for these fees, once the cast has been taken.
10. **All office products dispensed, opened, and used are nonrefundable.**
11. **A check returned from my financial institution is subject to a returned check fee of $50.**

Patient Signature _____

Guardian Signature, if applicable_____

Date Signed_____

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AGREEMENT TO USE CREDIT CARD FOR REMAINING BALANCES, COPAYS, AND DEDUCTIBLES.

To ensure full payment for services rendered, we require that ALL patients maintain a valid credit card on file. At check-in, your credit card information will be securely stored along with your health records. We are often required to collect **balances such as copay, coinsurance, and deductible** that your insurance will not pay on your behalf. These are charges that **YOU are responsible for** according to your insurance policy. You can find these charges on your claim after your insurance processed your visit. It is called the Explanation of Benefit (EOB). We encourage you to call your insurance company to find out more about your financial responsibilities if you are unsure.

If you do not wish to leave a credit card on file and prefer an invoice, please fill out the 1st page of the form in its entirety.

Cancellation and No Show Policy:

In fairness to other patients and the doctors, you will be charged a non-refundable **$50.00** for cancellation within 24 hours of appointment time or NO SHOW to your appointment.

A $250.00 for cancellation within 3 days or no show for **in-office surgery procedures**.

$500.00 for cancellation within 5 days or no show for **hospital or surgery center surgery appointment**.

I have read the above, understand and AGREED to this agreement.

I certify that I am an authorized user of this credit card, and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Visa __ MasterCard__ Discover__ American Express__ Other__ Name on card: _____ Credit Card Number: _____ Exp. Date: ___ /_____CCV/CID: _____ Billing Zip code: _____
Signature:
Date: