ORANGE COUNTY FOOT & ANKLE GROUP

Today's Date/ Fecha: _____

Primary Care Physican/ Médico de Atención Primaria:_____ Dr. Phone #/ *Teléfono de Medico:* _____

PATIENT INFORMATION/ INFORMACIÓN DEL PACIENTE:

Patient's Name:_____ Date of Birth: _____
Nombre de Paciente *Last/apellido* *First/Nombre* *Middle* *Fecha de Nacimiento*

Address/ *Dirección:*_____ City/ *Ciudad:* _____ Zip Code/ *Código Postal* _____

Home #/ *Telefono de Casa*:_____ Cell/ *Celular*::_____Email Address/ *Correo Electrónico*:_____

Drivers Lic. #_____ SSN _____ Marital Status/Estado Civil:_____

Occupation/ Ocupación:_____ Employer/ *Empleador*:_____ FT/ PT

Employer Address/ *Dirección del Empleado*:_____ Employer Phone/ Teléfono del Empleador:_____

INSURANCE INFORMATION/ INFORMACIÓN DEL SEGURO:

Priamary Insuance Name/ Nombre del Seguro Primario:_____ Provider Services Tel #: _____

Member ID/ *Identificación de Miembro*: _____ Group Number/ Número de grupo: _____

Secondary Insuance Name/ Nombre del Seguro Secundario:_____ Provider Services Tel #: _____

Member ID/ *Identificación de Miembro*: _____ Group Number/ Número de grupo: _____

RESPONSIBLE PERSON/ PERSONA RESPONSIBLE:

Subscriber/ Policy Holder/ *Suscriptor / Titular de la Póliza*:_____

Relationship to Patient/ *Relación al Paciente*: _____ Birth Date/ *Fecha de Nacimiento*:_____ SSN_____

Home #/ *Telefono de Casa*:_____ Cell/ *Celular*:_____ Email Address/ *Correo Electrónico*:_____

Address/ *Dirección:*_____ City/ *Ciudad:* _____ Zip Code/ *Código Postal* _____

Occupation/ Ocupación:_____ Employer/ *Empleador*:_____ FT/ PT

EMERGENCY CONTACT/ CONTACTO DE EMERGENCIA:

Name/ *Nombre:* _____ Relationship to Patient/ *Relación al Paciente*: _____

Address/ *Dirección:*_____ City/ *Ciudad:* _____ Zip Code/ *Código Postal* _____

Home #/ *Telefono de Casa*:_____ Cell/ *Celular*:_____Email Address/ *Correo Electrónico*:_____

I authorize the office to leave medical and/insurance information with/ ***Autorizo a la oficina a dejar información médica y del seguro con:***

[ ] Spouse/ Esposo/a [ ] Family/ Familia [ ] Voicemail/ Correo de Vos [ ] Patient Only/ Solo al Paciente

ORANGE COUNTY FOOT & ANKLE GROUP

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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Orange County Foot & Ankle Group. I understand that I am financially responsible for any balance. I also authorize Orange County Foot & Ankle Group or insurance company to release any information required to process my claims.

Date/ *Fecha*:_____ Signature/ *Firma*:_____

PATIENT HEALTH INFORMATION/ INFORMACIÓN DE SALUD DEL PACIENTE:

Patient's Name: _____ Birth Date: _____
Last /Apellido *First /Nombre* *Middle* *Fecha de Nacimiento*

Age/*Edad*: _____ Sex/ *Sexo*: [F] [M] [Other/ *Otro*] Height/*Estatura*: _____ Weight/*Peso*:_____ Pregnant/ *Embarazada*: [Y] [N]

Briefly describe your foot & ankle problem/ *¿Cuál es el problema de su pie(s)/Razon de su visita?:*_____
_____

Have you ever had foot surgery?/ *¿Ha tenido cirugía de los pie?:* [Y] [N] If yes, when?/ *¿Cuando?:* _____

For what condition?/ *¿Por cual condición?:* _____

Referred By/ Referido por: [Google] [Yelp] [Doctor] [Family] [Friend] [Other]: _____

MEDICAL HISTORY/ HISTORIAL MÉDICO:

Please mark yes or no to all that apply or that have occurred in the past. Marque sí o no a todas las que correspondan o que hayan ocurrido en el pasado.

Diabetes	**[Y] [N]**	Stomach trouble/*Problemas estomacales*	**[Y] [N]**
High blood pressure/*Alta presion sanguinea*	**[Y] [N]**	Heart trouble/*Problemas de el corazon*	**[Y] [N]**
Bleeding problems /*Problemas de sangrado*	**[Y] [N]**	Rheumatic Fever/*Fiebre reumática*	**[Y] [N]**
Kidney Disease/*Enfermedad del rinon*	**[Y] [N]**	Low back pain/*Dolor de espalda*	**[Y] [N]**
Numbness in feet or legs/*Adormecimiento en pies o piernas*	**[Y] [N]**	Varicose Veins/*Venas varicosas*	**[Y] [N]**
Ulcers U*lceras*	**[Y] [N]**	Palpitations/*Palpitaciones*	**[Y] [N]**
Stroke/*Derrame cerebral*	**[Y] [N]**	Leg Cramps/*Calambres en las piernas*	**[Y] [N]**
Heart Murmur/*Soplo Cardiaco*	**[Y] [N]**	Liver Disease/*Enfermedad del hígado*	**[Y] [N]**
Gout/*Gota*	**[Y] [N]**	Hepatitis	**[Y] [N]**
Tuberculosis	**[Y] [N]**	Broken bones/*Huesos rotos*	**[Y] [N]**
Cancer	**[Y] [N]**	Infections/ I*nfecciones*	**[Y] [N]**
AIDS or HIV/*SIDA o VIH*	**[Y] [N]**		
Other Conditions/ Surgeries?/ *¿Otras Condiciones / Cirugías:*			

Family History/ *Historia familia:* [ ] Diabetes [ ] High Blood pressure/ *Alta presion* [ ] Heart Disease/ *Enfermedad del corazón*

[ ] Stroke/ *Derrame cerebral* [ ] Foot or leg problems/ *Problemas de pies o piernas*

Shoe Size?/ *¿Tamaño del zapato?:*_____ Do you consider yourself in good health?/ *¿Se considera en buena salud?:* [Y] [N]

Do you smoke? /*Fuma?:* [Y] [N] [Former Smoker] If so for how long?/ *¿Si es asi, por cuanto tiempo?:*_____

Do cuts and wounds heal slowly?/ *¿Las heridas y cortadas se le curan lentamente?:*[Y] [N]

How many hours are you on your feet each day?/ *¿Cuantas horas está en sus pies cada día?:*_____

ORANGE COUNTY
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Do you partake in any sports or physical activities?/ *¿Participa en algún deporte o actividad física*?: _____

(check all that apply/ *marque todo lo que corresponda*):
Do you experience: numbness/ *entumecimiento*___, tingling/ *hormigueo*___, burning/ *ardor*____, sharp shooting pains/ *dolores punzantes agudos*_____ in your legs or feet/ *en las peirnas o pies*?

Have you ever been diagnosed with peripheral neuropathy/ *¿Alguna vez le han diagnosticado neuropatía periférica?* ____, diabetes____ or any condition affecting your nervous system/ *o cualquier condición que afecte su sistema nervioso*_____?

PHARMACY INFORMATION: INFORMACION DE FARMACIA:

Patient's Name: _____ Birth Date: _____
Last /Apellido *First /Nombre* *Middle* *Fecha de Nacimiento*

Pharmacy Name/ *Nombre de la farmacia:* _____ Phone/ *Teléfono:* _____

Address/ *Dirección:*_____ City/ *Ciudad:* _____ Zip Code/ *Código Postal* _____

Allergies/ Alergias (please circle/ *(porfavor circule*): None/*ninguna* Penicillin/*Penicilina* Sulfa Local Anesthetics/*anestésicos locales*

Iodine/*Yodo* Codeine/*Codeina* Adhesive Tape/*Cintas adhesivas* Latex/ *Látex* Other/*Otro* _____

MEDICATION LIST/ LISTA DE MEDICAMENTOS:

MEDICATION/ MEDICAMENTO:	**DOSE/ DOSIS:**

ORANGE COUNTY
FOOT & ANKLE GROUP

Today's Date/ Fecha: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION/ AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA:

Physician/ Facility:
_____

Address:
_____
_

_____
_

Telephone #: (_____)_____ Fax #: (_____)_____

I, _____ authorize my medical records to be released to Orange County Foot &

Patient Name (printed)

Ankle Group.

Medical records being requested in include:

[ ] Complete Records [ ] History & Physical [ ] Lab Reports [ ] Progress Notes
[ ] Pathology Reports [ ] Hospital Reports [ ] Operative Reports [ ] Medication Record
[ ] Radiology Reports: _____ [ ] Others:
_____

Signature: _____ Date of Birth: _____

Date: _____

ORANGE COUNTY
FOOT & ANKLE GROUP

Today's Date/ Fecha: _____

Please Fax Medical Records to:
Tustin Office: (714) 832-0272
Fullerton Office: (714) 888-6867

Fullerton Office
300 N. Euclid
Fullerton, CA 92832

Tustin Office
2492 Walnut Ave. Suite 220
Tustin, CA 97870

Phone **(714) 888-6860**

www.ocfeet.com

NOTICE OF PRIVACY PRACTICES

This Notice describes how Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make changes in out privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at our office.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will disclose protected heath information to other physicians who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

ORANGE COUNTY
FOOT & ANKLE GROUP

Today's Date/ Fecha: _____

Health Care Operations: We may use or disclose, as need, your protected health information in order to conduct certain business and operation activities. These activities include but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.
For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.
We will share your protected health information with third party "business associates" that perform various activities (e.g, billing, and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
We may use or disclose your protected health information, as necessary, to provide your with information about treatment alternatives or other health-related benefits and services that my be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send your information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Use and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below. You may give use written authorization to use your protected health information or to disclose I to anyone for any purpose. If you give us an authorization, you may revoke I in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If your are unable to agree or object to such a disclosure, we may use or disclose protected health information to notify or assist in notifying a family member, persona representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that ma be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us at our office.

Research: Death: Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit program, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe your have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

ORANGE COUNTY
FOOT & ANKLE GROUP

Today's Date/ Fecha: _______________

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or apprehend and individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law.
For example, to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized workers' compensation or similar laws. Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose limited information to a law enforcement official

Law Enforcements: We may disclose your protected health information to as law enforcement official concerning the protected health information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture and individual who has admitted to participation in a crime or has escaped from lawful custody.

Patients Rights
Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to your doctor to obtain access to your protected health information. You may also request access by sending us a letter to our office. If you request copies, we will charge you a fee for your health information, for x-rays and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us at our office for a full explanation of our fee structure
Restriction Request: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additions restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.
Confidential Communications: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

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I acknowledge that I received this Notice of Privacy Practices, and have read (or had the opportunity to read if I so choose) and understood the Notice.

______________________________ ______________________________
Patient name (please print) Parent or Authorized Representative (if applicable)

______________________________ __________________
Signature Date