FOR OFFICE USE ONLY:
- ☐ Verified
- ☐ Scanned
- ☐ HX Input

NEW PATIENT REGISTRATION

Patient Name(Last, MI., First): ______________________________

Home Address: ______________________________

Mailing Address: ______________________________

Home Phone: ____________________ **Cell Phone:** ____________________

Email: ______________________________

Patient's Social Security Number: ______________ **Driver's License Number:** ______________

DOB: __________ **Gender:** ___ **Male** ___ **Female** **Ethnicity:** ____________________

Primary Language: ______________ **Primary Physician:** ____________________

How did you hear about us? ______________________________

EMPLOYER/OCCUPATION

Name of Employer: ______________________________

Address: ______________________________

Phone: ______________________________

EMERGENCY CONTACT

Name: ____________________ Address: ____________________

Relationship to Patient: ____________________ Phone: ____________________

INSURANCE INFORMATION

Primary Insurance:

Name: ____________________ Address: ____________________

Phone: ____________________ Insurance ID #: ____________________

Subscriber's Name: ______________________________

Subscriber DOB: ______________ Relationship to Subscriber: ____________________

Secondary Insurance:

Name: ____________________ Address: ____________________

Phone: ____________________ Insurance ID #: ____________________

Subscriber's Name: ______________________________

Subscriber DOB: ______________ Relationship to Subscriber: ____________________

I give consent to and authorize treatment for myself or any minor child that may be necessary in judgement of the physician and /or medical personnel.

Signature: ______________________________ **Date:** ____________________

SYMPTOMS - INDICATE Y OR N, IF Y AND IF A LINE IS AVAILABLE, PLEASE INDICATE

Yes No	Yes No	Yes No	Yes No
☐ ☐ Ankle Sprain	☐ ☐ Diabetic Foot Exam	☐ ☐ Lumps	☐ ☐ Skin Lesion(s)
☐ ☐ Ankle Swelling	☐ ☐ Diabetic Foot Care	☐ ☐ Odor	☐ ☐ Toes Bend Oddly
☐ ☐ Athlete's Foot	☐ ☐ Excessive Sweating	☐ ☐ Nail Fungus	☐ ☐ Toe Pain
☐ ☐ Ankle Popping	☐ ☐ Flat Feet	☐ ☐ Orthotics	☐ ☐ Toe Deformity
☐ ☐ Arthritis Foot or Ankle	☐ ☐ Gout	☐ ☐ Painful Bump	☐ ☐ Wart
☐ ☐ Bunions	☐ ☐ Heel Pain	☐ ☐ Pale Toes or Feet	☐ ☐ White Feet or Toes
☐ ☐ Blue Feet or Toes	☐ ☐ High Arches	☐ ☐ Rash Leg or Feet	☐ ☐ Wound Not Healing
☐ ☐ Cramping	☐ ☐ Hot Feet or Toes	☐ ☐ Shin Splints	☐ ☐ White Feet or Toes
☐ ☐ Cold Toes	☐ ☐ Ingrown Nail(s)		

Yes No	Yes No
☐ ☐ Are you here due to injury? Describe... ________________	☐ ☐ Do you have pain or numbness, if so where? ________________
☐ ☐ Have you ever been diagnosed with Arthritis or Gout, if so, what type? ________________	☐ ☐ Do you have muscle weakness, if so where? ________________
	☐ ☐ Do you have burning or tingling, if so where? ________________
	☐ ☐ Any other concerns? ________________

HOW DID THIS OCCUR AND HOW LONG HAVE YOU BEEN EXPERIENCING SYMPTOMS?

Yes No	Yes No	Yes No
☐ ☐ Recent Trauma	☐ ☐ Sudden Onset	☐ ☐ Work Related Injury
☐ ☐ Improper Shoes	☐ ☐ Gradual Onset	☐ ☐ Date of Injury/Pain Started: ________

Duration of Symptoms:

Days: ________ Weeks: _________ Months: _________ Years: __________

Have you seen another physician for this problem? ☐ Y ☐ N If so, what treatment was provided?

____

Are you seeking a second opinion? ☐ Y ☐ N If so, who referred you for a second opinion?

____

What treatment have you had?

____

What treatments have you tried to fix the issue?

☐ Orthotics ☐ Injections ☐ Surgery ☐ Physical Therapy

☐ Medications: ______________________________ ☐ Other: ______________________________

Height: ______________________ Weight: ____________________ Pregnant: ☐ Y ☐ N ☐ N/A

GENERAL SYMPTOMS - INDICATE Y OR N, IF CURRENTLY EXPERIENCING SYMPTOMS

Yes	No	
☐	☐	Do you drink any alcohol, more than 4 drinks per week or more than 2-3 drinks per occasion?
☐	☐	Do you take any illicit drugs?
☐	☐	Do you experience pain in your buttocks, hips, legs, feet or arms that go away with rest?
☐	☐	Do you have any hair loss in your legs or feet?
☐	☐	Do you currently have any constipation or diarrhea?
☐	☐	Do you currently smoke or take tobacco substances?
☐	☐	Do you have any swelling/pain in legs? If Y, how many blocks can you walk before discomfort? ______________________________
☐	☐	Do you have any light headedness, weakness, faintness or dizziness?
☐	☐	Do you now or have you ever experienced nausea?
☐	☐	Do you have any urinary issues?
☐	☐	Do you have or have you had any wounds, ulcers or infections that were slow to heal?

MEDICAL HISTORY - INDICATE Y OR N, IF IN FAMILY OR IF CURRENTLY EXPERIENCING

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal EKG in the past	☐	☐	Epilepsy	☐	☐	AIDS/HIV
☐	☐	Angina or Chest Pain	☐	☐	High Cholesterol/Blood Pressure	☐	☐	Thyroid
☐	☐	Arthritis / RA / OA / Gout	☐	☐	Liver Disease	☐	☐	Weight Gain
☐	☐	Blood Clots	☐	☐	Back Pain	☐	☐	Weight Loss
☐	☐	Kidney Dysfunction	☐	☐	Obesity	☐	☐	Varicose Veins
☐	☐	Diabetes ☐ T-I ☐ T-II	☐	☐	Respiratory (Asthma, Allergies, COPD)	☐	☐	Other

MAJOR MEDICAL EVENTS - INDICATE Y OR N, IF ANY OF THE EVENTS HAVE HAPPENED

Yes	No		Yes	No		Yes	No	
☐	☐	Artificial Heart Valve/Stent/CHF	☐	☐	Chemical Dependency	☐	☐	Heart Attack / Stroke
☐	☐	Cancer Type: ____________	☐	☐	Chronic Wounds	☐	☐	Tumor(s)

PLEASE INDICATE SURGICAL HISTORY, IF ANY

Surgical Procedure: __________________________ Date: ___________ Complications: __________________

Surgical Procedure: _________________________ Date: ____________ Complications: __________________

MEDICATION HISTORY

Name:___________________________Dosage:_______________Frequency:________________________

Name:___________________________Dosage:_______________Frequency:________________________

Allergies to Medications, if any: ____

Aaron S. Bean DPM
Brian J. Schneekloth DPM
Adam M. Rife DPM

Phone: (760)565-5545

79405 Highway 111
Suite #103
La Quinta, CA 92253

Fax: (760) 424-5578

FINANCIAL AGREEMENT

All copayments and any outstanding patient account balances are due on the day of service. Please be advised that copayments are not able to be waived, the insurance companies hold the physician's office in violation of the contract when waiving a patient's copayments.

It is the patient's responsibility to know their insurance coverage. Our staff is happy to assist, upon request, to gather information about your insurance's deductible, copayment and out of pocket expenses.

We will attempt to bill your insurance for covered services and procedures. After 60 days, from the initial insurance submission, if we do not receive payment you will be expected to pay for services in full. If your claim is denied we can assist you in contacting your insurance for coverage if in fact your services are denied. We will attempt to resubmit with appropriate clinical data for denials.

We reserve the right to reschedule your appointment if you are unable to pay your outstanding balance and/or copayment on the day of your appointment.

______________________________ Signature

______________________________ Date

______________________________ Print Name

______________________________ Relationship to Patient

______________________________ Patient Name

______________________________ Patient DOB

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 48 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 48 hours notice, we are unable to offer that slot to other people.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients may be subject to a $50.00 fee for office appointment No Show.

The Cancellation and No Show fees are the sole responsibility of the patient. No Show fees must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication.

You can email our scheduling department at scheduling@westcoastfootandankle.com, call our office, or utilize our portal to reschedule your appointment. Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

______________________________	______________________________
Signature	**Date**
______________________________	______________________________
Print Name	**Relationship to Patient**
______________________________	______________________________
Patient Name	**Patient DOB**

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Release of Medical Records or Request for Medical Records

I,____ **DOB:** ____________________

Hereby Request Medical Records From: ____

Address: ____

Phone: __________________ **Fax:** _______________ **Email:** ________________________

My Records need to be sent to: West Coast Foot and Ankle Center

Address: 79405 Highway 111, Suite 9-469, La Quinta, CA 92253

Phone: (760) 565-5545 **Fax:** (760) 424-5578 **Email:** scheduling@westcoastfootandankle.com

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following, for the purpose of:

_____ **Continued Care** _____ **Litigation** _____ **Disability** _____ **Other (please specify):**

Please send: ☐ **All Medical Record** ☐ **Imaging (CT, X-Ray, MRI, Etc.)** ☐ **Lab Results**

Dates of Services requested: _______________ **through** _______________

Patient Signature: ____

Signature of Patient/Guardian: _________________________________ **Date:** _____________