WELCOME

CONNIE WONG, DPM and KI SANG YI, DPM INC
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Tel: (562) 597-5100 Fax: (562) 597-5165

PATIENT INFORMATION

Patient _____ (FIRST / MIDDLE / LAST)
Address _____ (Street / Apt.)
_____ (City / State / Zip)
Home Phone _____ Work _____ Ext _____
Sex: ☐ M ☐ F Age ____ Birthdate _____
Patient SS# _____
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse's Name _____
SS# _____ Birthdate _____
Spouse's Employer _____
Address _____
Employer Phone _____
Primary Care Physician _____
Address _____
Phone _____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION
(if different from patient)

Name _____
SS # _____ DOB _____
Address _____
Home Phone _____ Work _____ Ext _____

IN CASE OF EMERGENCY

Name _____
Address _____
Home Phone _____ Work _____ Ext _____
Relationship to Patient _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Do you need a referral? _____
Do you have a copay? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Connie Wong, DPM and Ki Sang Yi, DPM Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges wether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized benefits be made to Connie Wong, DPM and Ki Sang Yi, DPM Inc for any services furnished me by that physician. I authorize any holder of med- ical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature au- thorizes releasing of the information to the insurer or agency shown. In Medicare as- signed cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____
_____
_____
_____

When did it start? _____
What Treatment(s) have been tried? _____
_____
_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No
If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Callus	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar's Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

REORDER #9904304