Welcome To Our Office **Connie Wong, DPM** **Ki Yi, DPM** PLEASE PRINT

Last Name	First	Middle Initial	Gender: M / F	Date of Birth

Spouse's Name, Parent's or Guardian's Name if Minor

Residence Address	City	State	Zip Code	Marital Status:

Phone Number	Social Security Number

Whom May We Thank for Referring You?	Name and Phone Number of Person to Contact in Case of Emergency

List any Medical Conditions You Have (allergies, impairments, etc)

Name of Your Medical Doctor	Are you Currently Under Your Physician's Care?

If Yes For What?	When Did you last see Your Doctor?	May We Contact Your Physician For Your Medical Records?

Have You Had Previous Treatment By a Podiatrist?	When?	For What?	Podiatrist's Name

My Chief Foot Complaint Is:

This Condition Has Existed For How Long?	Are You Pregnant At This Time?

What Medications Do You Currently Take?

Do you have or have you had any of the following:

						Are you allergic to:	
Foot or Leg Injuries	YES / NO	Diabetes	YES / NO	Anemia	YES / NO	Novocaine	YES / NO
Foot or Leg Surgery	YES / NO	Heart Trouble	YES / NO	Gout	YES / NO	Penicillin	YES / NO
Foot or Leg Cramps	YES / NO	Epilepsy	YES / NO	Fainting Spells	YES / NO	Adhesive Tape	YES/NO
Foot or Leg Numbeness	YES / NO	Liver Disease	YES / NO	Bleeder	YES / NO	Materials	YES / NO
Knee Pain	YES / NO	Kidney Disease	YES / NO	Blood Disease	YES / NO	Drugs	YES / NO
Unequal Leg Length	YES / NO	Rhematic Fever	YES / NO	Circulation Problems	YES / NO	Foods	YES / NO
Weak Ankles	YES / NO	High Blood Pressure	YES / NO	Hardening of Arteries	YES / NO	Other	YES / NO
Bunions	YES / NO	Polio	YES / NO	Varicose Veins	YES / NO		
Foot Skin Problems	YES / NO	Bursitis	YES / NO	Arthritis	YES / NO		
Toe Nail Problems	YES / NO	Stomach Ulcers	YES / NO	Cancer	YES / NO		
Low Back Pain	YES / NO	Asthma	YES / NO	Prone To Infection	YES / NO		

I hereby give permission to Connie Wong, DPM/ Ki Yi, DPM to examine and treat my feet.

Patient's, Parent's or Guardian's Signature____________________________________ Date:______________________

CONNIE WONG, DPM and KI SANG YI, DPM INC.
1703 Termino Ave, Suite 103, Long Beach, CA 90804
V: 562-597-5100 F: 562-597-5165

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understood the notice.

AGREEMENT FOR PAYMENT OF SERVICES

Thank you for choosing Connie Wong, DPM and Ki Sang Yi, DPM INC. We accept most insurance plans and are affiliated with many health care plans.

Your insurance policy is a contract between you and your insurance company.
You are responsible for your bill.

It is your responsibility in knowing your plan's limitations, precertification requirements, deductibles, etc. so as to avoid any unexpected unpaid charges. As a courtesy to all our patients, we will bill your insurance.

Co-payment and/or deductibles are due on the date of service unless prior financial arrangements have been made. We accept cash, check, and credit cards.

APPOINTMENT REMINDERS ARE DONE AS A COURTESY

I understand there is a **$40** missed appointment fee if not cancelled 24 hours in advance.

Patient Name (Please Print) ______________________ Date ____________

Parent or Authorized Representative (If Applicable) ______________________

Signature ______________________

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In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made available by alternative means, such as sending correspondence to the individual's office instaed of the indiviudual's home.

I wish to be contacted in the following manner (check all that apply):

TELEPHONE AND EMAIL CONTACT

Our office uses the telephone and email as a means of communication with our patients (i.e. our office policy requires the staff to call our patients the day before to remind them of their appointment or to

☐ I authorize telephone contact

Home phone number: ______________________

Cell phone number: ______________________

Work phone number: ______________________

☐ I authorize email contact

Email: ______________________

AUTHORIZATION FOR TEXT MESSAGING

By signing this form I authorize Connie Wong, DPM and Ki Sang Yi DPM Inc. to send text massages to my cell phone. I understand that text messaging rates apply to any messages received from Connie Wong, DPM and Ki Sang Yi, DPM Inc. I also understand that I or Connie Wong, DPM and Ki Sang Yi, DPM Inc. may revoke this permission in writing at any time. I agree not to hold Connie Wong, DPM and Ki Sang Yi, DPM Inc. liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my contact/cell phone number changes that I will inform them or be liable for any fees or charges incurred.

Name: ______________________ Cell #: ______________________

This authorization form will remain in effect until revoked in writing by me or Connie Wong, DPM and Ki Sang Yi, DPM Inc.

Signature: ______________________ Date: ______________

Privacy Disclaimer: Text messaging is provided as a service to members. Your information will not be shared or distributed in any way.