Comprehensive Footcare Clinic-Hawaii

Karen C. Yamaguchi, DPM and Christopher Yee, DPM

HELLO - Welcome to our office!

Please PRINT the following information. This information is important for our records and your health.

Name Of Patient _____ Age_____Marital Status _____
Mailing Address _____ Zip Code _____
Home Address _____ Zip Code _____
Home Phone _____ Business Phone _____Cell Phone _____
Birth Date _____ Gender Male ☐ Female ☐
Occupation _____ Employer _____ Address _____
Race_____ Ethnicity_____ Preferred Language_____
Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION **ADDITIONAL COVERAGE**

PRIMARY Insurance Co. _____ **SECONDARY** Insurance_____
Subscriber's Name_____ Subscriber's Name _____
I.D.# _____ Birth Date _____ I.D.# _____ Birth Date _____
Group#_____ Coverage Code _____ Group#_____ Coverage Code_____

MEDICAL INFORMATION

Name of your Family Physician _____ Phone #_____
Last Visit _____
Have you seen a Foot Specialist before? No ☐ Yes☐ Doctor's Name _____
Last Visit _____
State in your own words your medical reason(s) for coming in our office _____
_____

In Case of Emergency, whom should we notify? **PLEASE LIST 2 PEOPLE**
1) NAME _____ PHONE # _____ RELATIONSHIP_____
2) NAME _____ PHONE # _____ RELATIONSHIP_____

PLEASE CHECK THE FOLLOWING:

1. How is your general health? Good ☐ Fair ☐ Poor ☐
2. Are you now or have been under a Doctor's care during the past two years? Yes ☐ No ☐
3. Are you taking any medicine at the present time? Yes ☐ No ☐
   If YES, What_____
4. Have you ever had any of the following? ***(CHECK IF YES)***

☐ Diabetes	☐ HIV +	☐ Arthritis	☐ Tuberculosis	☐ Liver Problems
☐ Stomach Ulcers	☐ Stroke	☐ Asthma	☐ Cancer	☐ Leg cramps
☐ Heart Problems	☐ Glaucoma	☐ Pneumonia	☐ Hemophilia	☐ Thyroid
☐ Hepatitis	☐ Gout	☐ Kidney Problem	☐ Hypertension	☐ Rheumatic Fever
☐ Cholesterol	☐ Implants type:	☐ Circulation		

5. Do you smoke? ☐ **YES** ☐ **NO** if yes, how often_____
   or are you a former smoker? ☐ YES ☐ NO
6. What is your height? _____What is your weight?_____
7. Have you ever experienced any effects from: ***(CHECK IF YES)***

☐ Penicillin	☐ Sulfa Drugs	☐ Codeine	☐ Tape	☐ Cortisone
☐ Novocaine	☐ Aspirin		☐ Iodine	

Other Allergies to Medications (or) Food: _____
_____

Signature:_____ **Date:** _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will bound by this signature as thought the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(PRINT Name of Insured) **(Name of Insurance Company)**

to pay and hereby assign directly to Karen C. Yamaguchi, DPM, LLC all benefits, if any, otherwise payable to me for her services as described on the attached forms. I understand and I am financially responsible for all charged incurred. I further acknowledge that any insurance benefits, when received by and paid to Karen C. Yamaguchi, DPM, LLC will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber or Patient) **(Date)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR KAREN C YAMAGUCHI, DPM, LLC

I acknowledge that I had the opportunity to **READ** if I so choose and/or was provided a copy of the Notice of Privacy practices and that I read and understood the Notice.

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature