

Stephen J. Wagstaff, D.P.M.

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PATIENT INFORMATION (please print clearly)

Mr. Mrs. Ms. Dr. _____ Birth date _____

Address _____ City _____ Zip _____

Home _____ Cell _____ E-mail Address _____

Preferred Pharmacy (Name, City and Phone if known) _____

Employer _____ Occupation _____

Referred by _____ Regular Physician _____

Describe why you are here today _____

Emergency Contact Name _____ Phone _____ City/State _____

INSURANCE INFORMATION

If applicable, please provide your insurance card for copying and complete information below.

Name of Insured _____ Co-Pay \$ _____ Relationship _____

Insured Date of Birth _____ Insured Social Security# _____

Please note: If you require a **referral** or **authorization** for your office visits from your primary care physician and/or insurance company, it is your responsibility to obtain such and present it to the receptionist when you arrive.

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENTS

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Stephen J. Wagstaff, D.P.M., and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In event of default, I agree to pay all costs of collection and reasonably necessary attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. There is a \$50 phone consultation charge.

CANCELLATION POLICY: To ensure equal Patient access and office efficiency, absence or cancellations within 24 hours of a scheduled appointment will incur a \$25 fee.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restrictions concerning the use of my personal medical information: _____

Further, I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature _____

Date _____

**** Please make sure to sign this page and complete your Medical History on other side of this form ****

DATE: _____ Patient Name: _____

MEDICAL HISTORY

Who do you consider your personal physician? _____

Date of last physical exam? _____

Current Medications (please provide list if you cannot fit on this form) _____

Allergies/Sensitivities _____

Previous foot or ankle surgeries (include date and type) _____

When were the last X-rays taken of your feet and by whom? _____

Weight _____ Height _____ Shoe Size _____

PERSONAL HISTORY: Please check those that apply

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Immune Deficiency Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thick Scars/Keloid |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Poor Circulation | |

FAMILY HISTORY: Please check those that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | |

Do you smoke? No Yes Do you have replacement heart valves? No Yes

Do you have vascular grafts? No Yes Are you under active chemotherapy? No Yes

Do you have joint implants? No Yes Are you slow to heal after cuts? No Yes

Any abnormal bleeding or bruising? No Yes

Have you had any other serious illness? No Yes, please list _____

Female Patients: Are you pregnant? No Yes

Ethnicity American Indian or Alaska Native Native Hawaiian or other Pacific Islander
 Asian Black or African American White Hispanic/Latino