PATIENT INFORMATION

Name: _____ D.O.B: _____/_____/_____
Last First Initial

Sex: ☐ M ☐ F Social Security: _____-_____-_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Mailing Address: _____
Street City Zip

Phone # _____ Cell # _____

E-mail Address: _____

Employer: _____ Work Phone: _____ Ext: _____

Employer Address: _____
Street City Zip

Emergency Contact: _____ Phone: _____

Pharmacy _____ Phone _____

Address _____

Person Responsible for Bill: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Name _____ Home Ph. _____

Address _____ Work Ph. _____

Sex: ☐ M ☐ F D.O.B: _____/_____/_____ Social Security: _____-_____-_____

Employer _____

Emergency Contact: _____ Phone: _____

If Patient is dependent complete this section and circle relationship to responsible party: Spouse Parent Other

Dependent Name _____ D.O.B: _____/_____/_____ Sex ☐ M ☐ F

Primary Insurance _____ Subscribers Name _____

Policy Number _____ Group # _____ D.O.B: _____/_____/____

Secondary Insurance _____ Subscribers Name _____

Policy Number _____ Group # _____ D.O.B: ___/_____/_____

Patients Family Doctor _____

HOW DID YOU HEAR ABOUT US? _____

Synergy Specialists
medical group, inc.

Authorization to Release Healthcare Information

Patient's Name: _____

Date of Birth: _____

My confidential healthcare information and/or billing information may be discussed with the following people:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

_____ _____

Patient's Signature Date

Synergy Specialists Medical Group, Inc.

Jay S. Berenter, DPM, FACFS
Podiatric Medicine & Foot Surgery
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot Surgeons

Scripps/XiMED Building
9850 Genesee Ave. Ste 370
La Jolla, CA 92037

office: 858.450.9218
fax: 858.450.3296
www.synergysmg.com

Medical History

Patient Name: _____ DOB: _____/_____/_____

What is your foot problem?

_____

_____

_____

When did the problem begin? _____ Date (If any injury)_____

Describe any accident/event_____

First visit to a Doctor for this problem: ☐ Yes ☐ No

Describe any previous treatment or home remedies _____

Do you have or have you ever been treated for:

Diabetes	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No

List other health problems:

Please list your medications:

Are you slow to heal after cuts? [ ] Yes [ ] No

Any abnormal bruising or bleeding? [ ] Yes [ ] No

Height: _____ Weight: _____ Shoe size: _____

How much are you on your feet at work?

☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

List any sports /activities: _____

Allergies to injection, oral, or topical administration of:

Penicillin or other antibiotics?	☐ Yes	☐ No
Narcotics? (Codeine, Vicodin)	☐ Yes	☐ No
Local anesthetics?	☐ Yes	☐ No
Adhesive tape?	☐ Yes	☐ No
Latex?	☐ Yes	☐ No
Any other drug or medication?	☐ Yes	☐ No

Please list: _____

Do you smoke? ☐ Yes ☐ No

Do you drink alcoholic beverages?

☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Have you had your Flu shot? ☐ Yes ☐ No

Date of Flu shot _____

Have you had your Tetanus shot? ☐ Yes ☐ No

If so, what year _____

Please list previous medical or surgical problems: _____

Have you been treated for this problem before? _____

If female, are you pregnant? ☐ Yes ☐ No

Have you ever had foot surgery? ☐ Yes ☐ No When and by whom? _____

Have you had x-rays taken for this problem? ☐ Yes ☐ No When and by whom? _____

Jay S. Berenter, DPM

9850 Genessee Avenue Ste. 370
La Jolla, CA 92037

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

The Health Insurance Portability & Accountable Act of 1996 ("HIPPA") requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed.
We may use and disclose patient medical records only for the following purposes:

Treatment: Providing, coordinating, or managing health care and related services by one or more health care providers.

Payment: Activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)

Health care operations: Conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.

We may create and distribute non-identified health information by removing all references to individually identifiable information.
We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
Any other uses and disclosures may be made only with patient's written authorization. We have the right to change our ***Privacy Practices*** from time to time. Patients may request a current copy by writing to address indicated above.

Patients have the following rights with respect to their protected health information.
Patients may exercise these rights by submitting a written request to the address indicated above, attention Office Manager:

The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient.
The right to reasonable request to receive confidential communications of protects health information from this organization by alternative means or locations.
The right to inspect and copy protected health information.
The right to amend protected health information.
The right to receive an accounting of disclosures of protected health information.
The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practice and give my consent to use my protected health information under the conditions provided.

_____ _____

Patient or Guardian **Date**

You have my permission to leave messages for me on my home phone, cell phone or e-mail

_____ _____

Patient or Guardian **Date**

Print Submit Clear Form