



**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
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: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Person Responsible for Bill: ( ) Self ( ) Spouse ( ) Parent ( ) Other: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Sex: ( ) M ( ) F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Family Doctor: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

Synergy Orthopedic Specialists  
Medical Group, Inc.

Jay S. Berenter, DPM, FACFS  
Jamey A. Allen, DPM, AACFAS

Scripps/XiMed Building  
9850 Genesee Ave, Ste 510  
La Jolla CA 92037

Office: (858) 450-9218  
Fax: (858) 450-3296  
www.drberenter.com  
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: \_\_\_\_\_

Is this your 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

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 medical surgical problems: \_\_\_\_\_

\_\_\_\_\_

Have you been treated for this problem before? \_\_\_\_\_

If female, are you pregnant?  Yes  No

Have you ever had foot surgery before?  Yes  No

When and by whom? \_\_\_\_\_

Have you had x-rays taken for this problem?  Yes  No

When and by whom? \_\_\_\_\_

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## 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, custom 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 address indicated above, attention Office Manager:

The right to request restricting 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 disclosure 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**

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## ABOUT FINANCIAL ARRANGEMENT AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a part to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (Example: orthotics, post-op shoes, etc.).

We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help.

Due to the nature of the business in this office, there may be times when your insurance carrier will not reimburse for routine foot care, orthotics, and/or Durable Medical Equipment. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information above, and I certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or the above information. I authorize payment of medical benefits to the medical group named above.

I hereby give permission to the doctor to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition.

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**Patient or guardian**

---

**Date**

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# Authorization to Release Health 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