KEVIN A. COX, D.P.M.

5129 Garfield Street ~ La Mesa, CA 91941
Phone Number: (619) 465-3200
Fax: (619) 465-3700

LAST NAME: FIRST: M.I.:			
ADDRESS:			
CITY/STATE: ZIP CODE:			
HOME PHONE NUMBER: ( )	CELL PHONE NUMBER: ( )	DATE OF BIRTH: AGE:	
SOCIAL SECURITY NUMBER:	MARITAL STATUS: M /S / W / D	MALE / FEMALE	EMAIL ADDRESS:
EMPLOYER:	OCCUPATION:	BUSINESS PHONE NUMBER:	
EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE #:		
PERSON RESPONSIBLE FOR PAYMENT ON ACCOUNT:	RELATIONSHIP TO PATIENT:		
WHOM MAY WE THANK FOR REFERRING YOU?			
PRIMARY INSURANCE COMPANY:	COPAY:		
SECONDARY INSURANCE COMPANY:			
WHAT IS YOUR FOOT COMPLAINT/PROBLEM TODAY?			

I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO BE AWARE OF MY INSURANCE COVERAGE, BENEFITS, AND PLAN. I WILL INFORM THE OFFICE OF ANY INSURANCE CHANGES IMMEDIATELY. IF I MISINFORM THE OFFICE REGARDING MY INSURANCE, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED - NO EXCEPTIONS.

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS BY MY INSURANCE COMPANY TO BE MADE DIRECTLY TO DR. KEVIN A. COX, DPM, FOR SERVICES RENDERED. MY BILL IS DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. MY COPAYMENTS ARE DUE BEFORE SERVICES ARE RENDERED. I ALSO ACKNOWLEDGE THE OFFICE WILL BILL MY INSURANCE COMPANY AS A COURTESY TO ME, BUT IT IS MY RESPONSIBILITY TO PROMPTLY PAY ANY PART OF THE BILL THAT IS NOT COVERED OR IS APPLIED TO MY DEDUCTIBLE.

I HEREBY GIVE MY PERMISSION TO DR. COX TO EXAMINE, PHOTOGRAPH, ADMINISTER TREATMENT, AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT PROBLEM.

DATE: **SIGNATURE:**

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Date: _____

Patient's First Name: _____ Patient's Last Name: _____

Reasons for today's visit: _____

Which foot is bothering you? □ Right □ Left For how long? _____

Do you wear orthotics? □ Yes □ No If yes, how old are they? _____

What have you done to treat the problem yourself? _____

MEDICAL HISTORY

Primary Care Doctor: _____ Dr's Phone # _____

Are you taking any medications? (Including over the counter, herbs, contraceptives) □ Yes □ No

Medication Name	Dosage	Reason for Taking

Use other side of page to continue if necessary

Do you have any allergies to medications? □ Yes □ No If yes, please list:

Allergy/Medication Name	Reaction (Hives, Rash, Shortness of Breath)

Are you pregnant or nursing? □Yes □ No

Height: _____ Weight: _____

Check any of the following podiatry conditions you have had:

□ Flat Feet	□ Ankle Problems	□ Bunions	□ Hammertoes	□Diabetic Ulcers
□ Neuroma	□ Fungus	□ Warts	□ Ingrown Toenail	□ Callouses
□ Fracture	□ Heel Pain	□ Itching	□ Foot Odor	□ Swelling

Check any of the following conditions you have had:

□ Arthritis/Gout	□ Diabetes	□ Blood Clots	□ Swollen Feet/Ankles
□ Hepatitis	□ Epilepsy	□ Liver Disease	□ HIV/AIDS
□ Anemia	□ Stroke	□ Cancer/Tumors	□ High Blood Pressure

SOCIAL HISTORY

Smoking Status:
□ Current every day smoker □ Current someday smoker □ Former Smoker □ Never Smoker

Do you use tobacco products? □ Yes □ No If yes, type/amount/ how long: _____
Do you use illegal drugs? □ Yes □ No If yes, type/amount/how long: _____
Do you consume alcohol? □ Yes □ No If yes, type/amount/how long: _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

□ Extreme weight loss/weight gain	□ Ulcers/Wounds	□ Migraines	□ Seizures
□ Rheumatoid Arthritis	□ Bronchitis	□ Anemia	□ Chronic cough
□ High Blood Pressure	□ Heart/chest pain	□ Joint pain	□ Kidney disease

List any other health condition not listed above: _____
_____
_____

If you have had any surgeries, please list them here with approximate date: _____
_____
_____

If you have any implants (pacemaker/hardware), please list them: _____
_____

PHARMACY

Which pharmacy do you use? _____

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CANCELLATION POLICY/NO SHOW POLICY

Our office will send appointment reminders by phone (text/voicemail) or by email.

Preferred method of delivery: □ **Text** □**Voicemail** □ **Email**

Appointment reminders are done as a courtesy. **It is your responsibility to keep track of your appointments**. Our office will not be held responsible for missed appointments.

We understand that there are times when you must miss an appointment due to emergencies. However, a missed appointment leaves an empty slot that could have been used by a patient in need of medical care. We therefore request that patients who are unable to keep their appointment notify us at least 24 hours in advance.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollar ($25) fee; this fee will not be covered by your insurance company and must be paid before we can schedule a new appointment.

By signing below, you agree and understand our reminder and cancellation policies.

_____	_____	___/___/___
PRINT NAME	**SIGNATURE**	**DATE**

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NOTIFICATION OF PRIVACY PRACTICES:

By signing in the following space provided I hereby acknowledge that I have been informed of the privacy practices policy of The Achilles Podiatry Center. A paper copy of the privacy practices policy was offered to me. I have indicated below whether I accepted a copy of the policy or refused at this time. I understand that I can request a copy of this policy at any time.

- ☐ Yes, I accepted a copy of the privacy policy
- ☐ No, I refused a copy of the privacy policy at this time

Patient Name: _____

Signature of Patient or
Patient's Authorized Representative: _____

Relationship,
If other than Patient: _____

Today's Date: _____

PLEASE IDENTIFY A PERSON OR PERSONS THAT WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO (such as spouse, children, friend or caregiver):

_____

_____

Signature of Patient or
Patient's Authorized Representative: _____

Relationship,
If other than Patient: _____

Today's Date: _____

RECORD OF DISCLOSURES (other than for treatment, payment and healthcare operations):

DATE	DISCLOSED TO
_____	_____
_____	_____
_____	_____
_____	_____