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YEAR	
CHART #	

DR. ANTHONY J. FEDRIGO, DPM, FACFAS

1125 SIR FRANCIS DRAKE BLVD SUITE KENTFIELD, CA 94904 P: 415-461-6555 F: 415-461-6556

TODAY'S DATE_____ YOUR NAME _____

SS#_____ BIRTHDATE_____ BIRTH GENDER _____ SEXUAL ORIENTATION _____

YOUR ADDRESS_____APT #_____

CITY_____ STATE_____ZIP CODE_____

HOME PHONE_____WORK_____CELL_____

EMAIL ADDRESS_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

PHONE _____ PARENT (if minor): _____

EMPLOYMENT STATUS: ( ) FULL TIME ( ) PART TIME ( ) SELF ( ) RETIRED ( ) STUDENT

EMPLOYER_____ ADDRESS_____

PRIMARY PHYSICIAN_____ CITY _____

PHONE NUMBER _____ DATE OF LAST VISIT _____

PRIMARY INSURANCE_____POLICY ID #_____

NAME OF SUBSCRIBER (if different) _____ RELATIONSHIP_____

SUBSCRIBER BIRTHDATE_____ SUBSCRIBER SOCIAL SECURITY #_____

EFFECTIVE DATE_____ GROUP # _____ GROUP NAME _____

SECONDARY INSURANCE _____ POLICY ID# _____

NAME OF SUBSCRIBER_____ RELATIONSHIP _____

EFFECTIVE DATE_____GROUP#_____GROUP NAME _____

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree prior to treatment.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept Check and Visa or MasterCard credit cards only.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

SIGN _____ PRINT _____ DATE _____

PHARMACY_____ STREET ADDRESS _____

CITY_____PHONE # _____

WHO REFFERED YOU TO THIS OFFICE _____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING ( ) NONE ( ) LIST ATTACHED

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES AND/OR REACTION: (CHECK ALL THAT APPLY) () NONE

() LOCAL ANESTHIA	**() ASPIRIN**	**() ANTIBIOTICS**	**() ADHESIVE TAPE**	**() TETANUS VACCINE**
() TYLENOL	**() PENICILLIN**	**() SULFA DRUG**	**() CODEINE**	**() CORTISONE**
() STATINS	**() VICODIN**	**() IODINE**	**() MORPHINE**	**() OTHER_____**

REACTION_____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS (CHECK ALL THAT APPLY) () NONE

() HIGH BLOOD PRESSURE	() DVT/PHLEBITIS	() ARTHRITIS	() ASTHMA	() HEPATITIS
() ATRIAL FIBRILLATION	() VARICOSE VEINS	() GOUT	() THYROID CONDITION	() SEIZURES
() HEART DISEASE	() ANEMIA	() LOW BACK PAIN	() STROKE	() ULCERS
() BLEEDING DISORDER	() CANCER	() AIDS/HIV	() BLOOD CLOTS	() DIABETES 1/2
() RHEUMATIC FEVER	() KIDNEY PROBLEMS	() OTHER_____		

For women and all adults aged 65 and older:
How many times in the past year have you had **4 or more drinks in a single day? _____**

For men under 65 years of age:
How many times in the past year have you had **5 or more drinks in a single day**? **_____**

HAVE YOU HAD A ( ) FLU SHOT ( ) PNEUMONIA SHOT WITHIN THE LAST YEAR? Month _____ Year _____

DID YOU OR CURRENTLY USE TOBACCO? NO / YES: How long? _____ /Quit _____Years Ago

DO YOU HAVE DIABETES? NO / YES: what is your current HB A1C? _____ Last B/G # _____

HAVE YOU HAD ANY FALLS IN THE PAST YEAR? N / Y: ARE YOU TAKING CLASSES TO HELP WITH BALANCE/POSTURE? N / Y

WHAT AND WHERE IS YOUR PRESENT PROBLEM _____ LEFT / RIGHT

HOW LONG HAS IT BEEN BOTHERING YOU? _____WHAT MAY HAVE CAUSED IT? _____

HAVE YOU HAD PRIOR TREATMENTS? _____DO YOU HAVE ANY OTHER CONCERNS?_____

Have you had injuries to your: () FEET () ANKLES () KNEES () HIPS () BACK (CHECK ALL THAT APPLY)

Do you get numbness in your: () FEET () LEGS () HIPS () BACK () HANDS () ARMS (CHECK ALL THAT APPLY)

SHOE SIZE: _____ WEIGHT: _____ HEIGHT:_____LAST BLOOD PRESSURE _____/_____

DAILY EXERCISE_____

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL PROBLEMS? _____

HOSPITALIZATIONS/SURGERIES_____

SIGN _____ PRINT _____ DATE _____

FEDRIGO
PODIATRY, APC
Foot and Ankle Specialist

1125 Sir Francis Drake Blvd. Ste 1, Kentfield, CA 94904
P. 415-461-6555 F. 415-461-6556
www.footandanklespecialistsofmarin.com

IT IS OUR RESPONSIBILITY TO NOTIFY YOU OF LAWS REGARDING PATIENT PRIVACY AND PROCEDURES IN EFFECT. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU WOULD LIKE US YOU PROTECT IT. PLEASSE REVIEW IT CAREFULLY.

I AM AWARE THAT THE NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR ME TO READ HERE IN THE OFFICE, AND I MAY RECEIVE A COPY UPON MY REQUEST.

I AM AWARE THE STAFF WILL IDENTIFY THEMSELVES AS A DOCTORS OFFICE WHEN CONFIRMING APPOINTMENTS, RETURNING MY CALLS FOR A ROUTINE FOLLOW UP CALLS. I FURTHER UNDERSTAND ANY MESSAGE LEFT FOR ME WILL NOT INCLUDE TEST RESULTS OR OTHER IDENTIFIABLE MEDICAL INFORMATION, UNLESS PREVIOUSLY REQUESTED BY ME.

WHEN A PROVIDER GIVES MEDICAL ADVICE, DIAGNOSES, OR TREATMENT RECOMMENDATIONS VIA PHONE OR EMAIL, THIS IS CONSIDERED A FORM OF MEDICAL SERVICE DELIVERY. I UNDERSTAND AGREE AND CONSENT THAT MY INSURANCE, OR MYSELF, MAY BE BILLED FOR THESE SERVICES.

BY PROVIDING MY CELL PHONE NUMBER AND MY EMAIL, I UNDERSTAND, ACCEPT AND AGREE TO AUTHORIZE ANTHONY FEDRIGO, DPM; FEDRIGO PODIATRY, APC; FOOT AND ANKLE SPECIALISTS OF MARIN; ITS EMPLOYEES AND ASSOCIATES TO COMMUNICATE MEDICAL AND/OR FINANCIAL INFORMATION TO ME VIA TEXT OR EMAIL. I ACKNOWLEDGE THAT TEXT OR EMAIL COMMUNICATION IS NOT ENCRYPTED AND MAY NOT BE SECURE. I UNDERSTAND THAT THERE IS A RISK OF INTERCEPTION OR MISUSE OF THIS INFORMATION BY THIRD PARTIES. I AGREE AND RELEASE ANTHONY FEDRIGO, DPM; FEDRIGO PODIATRY, APC; FOOT AND ANKLE SPECIALISTS OF MARIN; ITS EMPLOYEES; ASSOCIATES AND FAMILIES OF ANY AND ALL RESPONSIBILITY FOR ANY LOSS OF CONFIDENTIALITY OR DAMAGES RESULTING FROM THE USE OF TEXT AND MY EMAIL FOR COMMUNICATION. I UNDERSTAND THAT I CAN REQUEST A PAPER COPY OF THIS INFORMATION AT ANY TIME. I ACKNOWLEDGE AND AGREE THAT I AM RESPONSIBLE FOR ANY RISKS ASSOCIATED WITH THE USE OF TEXT OR EMAIL FOR SENSITIVE INFORMATION.

I AM AWARE THAT DR. FEDRIGO MAKES IT A PRACTICE TO KEEP MY PRIMARY CARE AND OR SPECIALITY PHYSICIANS NOTIFIED OF MY PROGRESS BY SENDING A REPORT DETAILING MY INITIAL VISIT AND/OR SUBSEQUENT VISITS AS HE MAY CONSIDER NEEDED.

I AUTHORIZE DR. FEDRIGO AND HIS STAFF TO RELEASE PERTINENT INFORMATION TO ANY PHYSICIAN OR PROVIDER THEY REFER ME TO FOR FUTURE CARE.

I AUTHORIZE THE FOLLOWING PERSON (relative or friend) _____ TO HAVE ACCESS TO MY MEDICAL INFORMATION, INCLUDING TESTS, SCHEDULED APPOINTMENTS AND BILLING.

THIS INFORMATION IS IN EFFECT IMMEDIATELY AND SHALL REMAIN IN EFFECT UNTIL I GIVE FURTHER NOTICE.

SIGNATURE _____ DATE _____

PRINT NAME _____