VALLEY PODIATRIC
WOUND CARE

2900 Fresno St. #104, Fresno CA 93721
Phone: (559) 570-5377 / Fax: (559) 570-5317

Laura Rowe, DPM
Jeffrey Moy, DPM
Deborshi Dasgupta, DPM

## PATIENT INFORMATION

Today's Date: _____

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ ST:_____ Zip Code: _____

Email Address: _____

SSN: _____ Cell Phone: _____ Home Phone: _____

Occupation: _____ Employer: _____

Date of Birth: _____

Sex: Male Female (circle one)

Marital Status: Single Married Divorced Widow (circle one)

## RELEASE OF INFORMATION CONTACTS

I authorize to release my medical records to the following people:

| Name: | Relationship: | Phone Number: | *Check if Emergency Contact* |
|---|---|---|---|
| | | | ☐ |
| | | | ☐ |

## PRIMARY INSURANCE

Name of Insurance: _____

Name of Policy Holder: _____

ID #: _____ Group #: _____

Subscriber #: _____ DOB: _____

Patient Relationship to Subscriber: _____

Sex: M F

Tel #: _____

Social Security # _____- _____-_____

Occupation: _____

Employer: _____

## SECONDARY INSURANCE

Name of Insurance: _____

Name of Policy Holder: _____

ID #: _____ Group #: _____

Subscriber #: _____ DOB: _____

Patient Relationship to Subscriber: _____

Sex: M F

Tel #: _____

Social Security # _____- _____-_____

Occupation: _____

Employer: _____

**Assignment of Benefits:** I hereby assign all medical and surgical benefits to which I am entitled, including government programs, private insurance, major medical benefits and any other health plan to Valley Podiatric Wound Care. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure patient.

**Treatment Consent:** I hereby give consent for medical or surgical treatment to Dr. Deborshi Dasgupta and associates to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that Valley Podiatric Wound Care have made available to me their Notice of Privacy Practices. I am aware that I have been given a paper copy of the notice in this packet. I further acknowledge that a copy of the current notice is posted in the reception area.

### ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I hereby acknowledge that Valley Podiatric Wound Care have made available to me their Financial Policy. I am aware that I have been given a paper copy of the policy in this packet.

Signature of Patient: _____ Date: _____

Referring Physician: _____ Primary Care Physician: _____ Cardiologist: _____

## Medical History

Height: _____ Weight: _____ Last A1C (if diabetic): _____

Allergies to Medications: _____

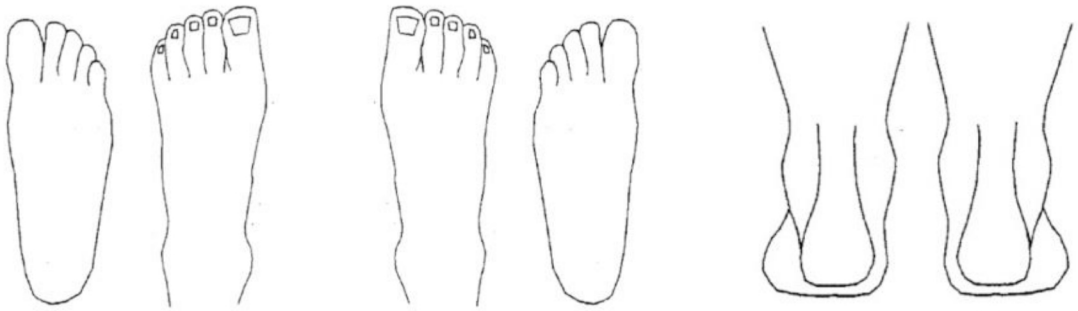
**What medical conditions do you have?**

_____

## Current Foot Problem

**Please mark areas of the foot that are of concern**

**Left Foot** **Right Foot** **Ankles** *(Back View)*




Current Foot Problem: _____

When did your problem begin? _____ Onset: Gradual Sudden (circle one)

Is the Problem getting worse, better, or staying the same?

☐ Worse ☐ Better ☐ Same

What makes it better? _____

What makes it worse? _____

Any other foot issues needing to be addressed today? _____

Was this caused by an injury? Yes No (circle one) Worker's Comp? Yes No (circle one)

## Social History

**Current Alcohol Use:** (circle one)

None Daily Seldom Former

**Current Tobacco Use:** (circle one)

None Daily Seldom Former

## What is your family's medical history?

_____

## Surgical History

Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

## Medications

*Please attach list of medication to the back of packet or write on the back of this paper if there are more medications than spaces provided below.*

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Pharmacy Name: _____ City: _____ Cross Streets: _____

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# PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ DOB: _____

I consent for medical imaging (photo, video, and/or audio) to be made of me. I understand that the information may be used in my medical record, for purposes of medical teaching at Valley Podiatric Wound Care, or for publication in medical textbooks or journals as I have designated below. By consenting to this medical photography I understand that I will not receive payment from any party. Refusal to consent to photographs, videos, and/or audio recording will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Valley Podiatric Wound Care.

By signing the form below, I confirm that this consent form has been explained to me in terms which I understand.

Please choose one of the following options:

- ☐ I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Valley Podiatric Wound Care and to be used in my medical record.
- ☐ I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication.
- ☐ I agree to the use of my image for medical records ONLY.
- ☐ I do not consent for my photo to be taken

SIGNATURE: _____ DATE: _____

PRINT NAME: _____