Robert Victor, DPM, FACFAS
578 Rio Lindo Ave, Ste 4
Chico, CA 95926
530-894-6195

Treatment of all Foot Disorders and Injuries

Personal Information:

Patient's Name: _____ Today's Date: _____
Last First M.I.

Patient's Address: _____ City/State: _____ Zip: _____

Phone: (_____)_____ Email Address: _____

Patient's SS#: _____ Date of Birth: _____ Sex: M / F

Employer Name: _____Employer Phone: _____

Employer's Address: _____

Marital Status: _____Spouse's Name: _____

If minor, name of both parents/guardians and DOB: _____

Shoe Size _____

Referral Information:

How did you hear about this office? _____

Your family physician:_____Date last seen_____

Medical Insurance Information:

Name of Subscriber: _____OR ☐ same as above

Subscriber SS#: _____Subscriber Date of Birth: _____

Relationship to patient:_____Employer:_____

Type of Insurance (we will make copies of cards at time of visit):

Primary Insurance: _____

Secondary Insurance (if applicable): _____

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Patient Name: _____ Today's Date: _____

Reason for being seen: _____ Problem Start Date: _____

What have you done for your foot problem? _____

Type of pain (circle all that apply): sharp, dull, aching, throbbing, burning, shooting, continuous, intermittent, localized, other: _____

Medical History

Major Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Angina (Chest pain)
- ☐ Heart Disease
- ☐ Arrhythmia
- ☐ Heart Murmur
- ☐ Stroke
- ☐ High Cholesterol

Gastrointestinal
- ☐ Acid Reflux
- ☐ GI or Rectal Bleeding
- ☐ Bowel Disorders
- ☐ Hernia
- ☐ Ulcers

Vascular
- ☐ Anemia
- ☐ Leg Pain When Walking
- ☐ Prolonged Bleeding
- ☐ Blood Clots
- ☐ Poor Circulation

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis

Arthritis
- ☐ Artificial Joints
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid
- ☐ Fibromyalgia

HEENT
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing Loss

Miscellaneous
- ☐ Bladder Problem
- ☐ Cancer (Type:_____)
- ☐ Hepatitis/Liver Disease
- ☐ Fainting
- ☐ Epilepsy/Seizure
- ☐ HIV
- ☐ Kidney Problem
- ☐ Muscle Disease
- ☐ Prostate Problem
- ☐ Thyroid Disease

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric Care
- ☐ Alcohol Dependence
- ☐ Drug Dependence

Other Medical Problems
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ NONE OF THE ABOVE

Family History
- ☐ Bleeding Disorder Relation:_____
- ☐ Anesthesia Complications Relation:_____
- ☐ Heart Disease Relation:_____
- ☐ Diabetes Relation:_____
- ☐ Cancer Relation:_____

☐ NONE OF THE ABOVE

Are you taking **medications**? (list below or attach a copy –including strength/dosage)

_____

What **operations** have you had?

_____

Allergies: If none Please check here ☐ No Known Adverse Drug Reactions

☐ Penicillin Reaction?	☐ Sulfa Drugs Reaction?	☐ Codeine: Reaction?
☐ Latex: Reaction?	☐ Adhesive Tape: Reaction?	☐ Novocaine/Local Anesthetic: Reaction?
☐ General Anesthesia Reaction?	☐ NSAIDS: Reaction?	Others (Name/Reaction)

Do you smoke? ☐yes ☐no If yes, _____packs per day OR ☐ Previous Smoker (Quit Date_____)
Do you drink? ☐yes ☐no If yes, _____drinks per day
(Women) Are you pregnant? ☐yes ☐no Breastfeeding? ☐yes ☐no

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PATIENT FINANCIAL POLICY

1. We will bill your primary (and secondary) insurance company as a courtesy to you provided we have all necessary information (including insurance company name and address), or we can provide a receipt for you to send to your insurance company. **If you do not have insurance, full payment is expected today.**

2. We will attempt to verify benefits for some specialized services or referrals. Patients are also encouraged to contact their plans for clarification of benefits prior to services rendered. In the event your health plan determines a service to be "not covered," you will be responsible for the charge.

3. Once the balance has been determined your responsibility, we will send you a statement. If we do not receive payment from you after the second statement, you will be charged a $10 late fee and given a final notice. Your account may then be turned over to a collection agency.

Your signature on this page certifies that you have read, understood and agreed to the policy stated above.

It authorizes the release of any medical information necessary to process this claim for services.

It authorizes payment of medical benefits to Dr. Robert M. Victor, DPM, FACFAS for services described on itemized statements and/or insurance forms.

Signature of Patient/Responsible Party: _____

Name of Patient/Responsible Party: _____ Date: _____

Reviewed and Witnessed by: _____

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ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature