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? ___________

Synergy Orthopedic Specialists Medical Group

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

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 restring 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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