Vanessa Taylor DPM INC.

CHINO HILLS FOOT & ANKLE CENTER

15944 LOS SERRANOS CTRY CLUB DR. #130 CHINO HILLS, CA 91709

PATIENT'S INFORMATION: DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ APT # _____

CITY: _____ STATE:_____ ZIP CODE: _____

PREFERRED PHONE (CELL/HOME) _____ MAY WE LEAVE A MESSAGE? YES ☐ NO ☐

ALTERNATE PHONE (CELL/HOME) _____MAY WE LEAVE A MESSAGE? YES ☐ NO ☐

E-MAIL ADDRESS: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

MARITAL STAUS: S M D W SEX: M F SHOE SIZE: _____ HEIGHT: _____ WEIGHT:_____

WHAT IS YOUR CHIEF FOOT COMPLAINT? _____

PRIMARY CARE DOCTOR:

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

WHO REFFERED YOU TO OUR OFFICE? _____

PERFFERED PHARMACY:

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

RESPONSIBLE PARTY INFORTAION:

NAME: _____ SSN: _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER: _____

RESPONSIBLE PARTY'S CELL PHONE# _____ WORK#: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

OCCUPATION: _____

PATIENT INSURANCE INFORAMATION:

PRIMARY INSURANCE COMPANY'S NAME: _____

(OVER)

SECONDARY INSURANCE COMPANY'S NAME: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____ ALT PHONE NUMBER: _____

MEDICAL INFORMATION:	YES	NO
DO YOU HAVE DIABETES?	**( )**	**( )**
IF YES , WHAT IS YOUR HgA1C LEVEL? _____		
DO YOU HAVE ALLERGIES?	( )	( )
IF YES, PLEASE LIST: _____		
ARE YOU UNDER A PHYSICIAN'S CARE?	( )	( )
IF YES, FOR WHAT? _____		
ARE YOU CURRENTLY TAKING ANY MEDICATIONS?	( )	( )
IF YES, PLEASE LIST:		
_____		
DO YOU HAVE HIGH BLOOD PRESSURE?	( )	( )
HAVE YOU EVER BEEN TREATED FOR HEART RELATED ISSUES, ASTHMA	( )	( )
EPILEPSY, RHEUMATIC FEVER, PHLEBITIS, ANEMIA, KIDNEY OR LIVER ISSUES?		
OTHER? _____		
ARE YOU OR HAVE BEEN A SMOKER?	( )	( )
IF YES: (CIRLCE ONE): CURRENT SMOKER / FORMER SMOKER DAILY USE: _____ PACKS OR STICKS		
RECEIVED THE FLU VACCINE?	( )	( )
IF YES, WHEN? _____		
RECEIVED THE COVID-19 VACCINE:	( )	( )
IF YES, DATE OF 1ST DOSE: _____DATE OF 2ND DOSE: _____		
RECEIVED A PNEUMONIA VACCINE:	( )	( )
IF YES, WHEN? _____		
DO YOU HAVE A LIVING WILL OR SOME ONE TO MAKE DECISIONS ON YOUR BEHALF?	( )	( )

TREATMENT AND INSURANCE AUTHORIZATIONS/ ASSIGNMENT: (PLEASE READ)

I HERBY AUTHORIZE ALL EXAMS, INCLUDING X-RAYS AND LABORATORY PROCEDURES, WHICH MAY BE NECESSARY AT A DOCTOR'S JUDGMENT FOR DIAGNOSTIC PURPOSES. I REQUEST THAT PAYMENT FOR MEDICARE, MEDI-CAL OR ANY OTHER INSURANCE CARRIER BE MADE DIRECTLY TO DR. VANESSA TAYLOR, DPM AND AUTHORIZE THE DISCLOSURE OF MEDICAL INFORMATION NECESSARY TO DETERMINE OR CLAIM THESE BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY COSTS NOT COMPENSATED BY MY INSURANCE.

PHOTOGRAPHIC DOCUMENTATION MAY BE TAKEN. I HEREBY AUTHORIZE THE USE OF MY PHOTOGRAPHS FOR TEACHING PURPOSES.

_____ ----------

PATIENT/ RESPONSIBLE PARTY SIGNATURE DATE

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CHINO HILLS, CA 91709

PHONE: (909)287-0677 FAX: (909)631-2919

ACKNOWLEDGEMENT 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 choose) and understand the Notice.

_____ _____

Patient Name (Please Print) Date

_____

Signature

_____

Parent or Authorized Representative (If applicable)