Allenmore Foot Care Center

Dr. Eddie P. Lo, & Dr. Natalie T. Chu

Podiatric Physicians & Foot and Ankle Surgeons

2302 South Union Ave Suite B18 Tacoma WA 98405

Phone: 253-572-4848 Fax: 253-572-1803

Patient Information

Name: _____________________ Middle Initial:________________ Last:_________________________

Date of Birth:_____________ Sex:________________ Race:_________________________ Hispanic/Latino? Yes No

Language: _______________ SSN:______________ Martial Status: ________________

Address:_______________________________ City:_________________State: _____________Zip Code: ______________

Pregnant? Yes No Employment Status:___________________Employer:____________________________________

Phone Number: ____________________Work Number: ____________________Cell Phone:____________________

Primary Care Physician:_______________________________ Phone:_________________________

Email Address:___________________________________ Referred By: _____________________________

Height: ____________ Weight:___________Shoe Size: _____________Previous Podiatrist:_________________________

MAY OUR OFFICE LEAVE DETAILED VOICEMAIL MESSAGE AT THE ABOVE LISTED NUMBERS?

Yes/No Home Work Cell

Pharmacy Name:____________________________ **Pharmacy Location:**_____________________________

Emergency Contact Information

Emergency First Name:__________________________ Last Name: ______________________________

Phone: _____________________ Relation to Patient: ____________________________

Address: ____City:____________________ State:_______________

Zip:________________

Guarantor: (Person responsible for payment if not self)

First Name: _____________________Middle Initial: _______________ Last Name: ________________________________

Date of Birth: ______________Sex: ________________Address: ____

City: ________________________State: ________________Zip: _________________

SSN: _____________________Martial Status: ___________________________

WHAT PROBLEM BROUGHT YOU TO OUR OFFICE? ____

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____

Allergies:	**Symptoms:**	**Severity**		
________________	________________	Mild	Moderate	Severe
________________	________________	Mild	Moderate	Severe
________________	________________	Mild	Moderate	Severe
________________	________________	Mild	Moderate	Severe
________________	________________	Mild	Moderate	Severe

Allergy to Latex? Yes No

Medications (Name, Strength, Dose) : ____

____

____

____

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Medical History	Yourself	Mother	Father
Arthritis			
Asthma			
Coronary Artery Disease			
Congestive Heart Failure			
COPD			
Cancer			
High Cholesterol			
Dementia			
Diabetes			
GERD			
Gout			
Headaches			
Hepatitis			
Hypertension			
MI (Heart Attack)			
Migraine			
Pneumonia			
Stroke			
TB			
Thyroid Disease			
Ulcer (GI)			
Other:			

Are You Currently under Chemotherapy? **Yes** **No**

Social History: **Tobacco** **No** **Yes** **Chewing** **Smoking:______/Packs Per Day**
Alcohol **No** **Yes** **Drinks Per Day:__________**
Recreational Drugs **No** **Yes**

PAST SURGERIES OF ANY TYPE?

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____

REVIEW OF SYMPTOMS: Please circle the symptoms that apply to you.

Head	Dizziness	Fainting	Headaches	Pain	Sweats
Nose	Bleeding	Discharge	Infections	Obstruction	
Mouth	Bleeding	Dentures	Dry Mouth	Post nasal Drip	
Ear	Hearing Aid	Infection	Ringing		
Throat/Neck	Hoarseness	Lumps	Sore Throat	Tenderness	
Respiratory	Asthma	Bronchitis	Cough	COPD	
	Pleurisy	Shortness of Breath		TB	Wheezing
Cardiovascular	Chest Pain	Cramps in Leg/Feet		Extremity(s) Cool	Hair Loss on Legs
	Heart Murmur	High BP	History of MI	Leg or Foot Ulcer	Varicose Veins
	Palpations	Replacement of Heart Valve		Rheumatic Fever	Vascular Garfts

(CONTINUED)

Gastrointestinal	Antacid use, Constipation, Diarrhea, Excessive Thirst, Gall Bladder Disease, Heart Burn, Hemorrhoids, Hepatitis, Jaundice, Laxative, Liver Disease, Nausea, Rectal Bleeding, Swallowing Problem
Musculoskeletal	Ankle Sprain, Arch Pain, Arthritis, Back Problems, Childhood Foot Problems, Corns, Flat Feet, Gait(Walking Problem), Gout, Hammer/Mallet Toes, Heel Pain, High Arch Feet, In-Toeing, Joint Pain, Joint Stiffness, Joint Implants, Lower Back Pain, Muscle Cramps, Muscle Stiffness, Neuroma, Orthotic Use, Paralysis, Restricted Motion, Shoe Insert use, Toe Walking, Weakness
Psychiatric	Depression, Disorientation, Memory Loss
Skin	Athlete's Foot, Dryness, Eczema, Fungal Nails, Hives, Ingrown Nails, Itching, Keloid Scar, Lumps, Mole Changes, Rash, Warts
Neurological	Black Outs, Burning, Charcot Neuroathy, Fainting, Neuroma, Numbness, Speech Disorders, Strokes, Tinginling, Tremors, Unsteady Gait
Endocrine	Fatigue, Goiter, Sweats, Thirst, Thyroid, Weight gain, Weight Loss
Hematologic/Lymph	Anemia, Bleeding Easily, Blood Clots, Easy Bruisability, Recent Chemotherapy, Slow healing Cuts, Swollen Glands, Transfusion Reaction
Allergic/Immunologic	Hives, Itchy Eyes, Itchy Nose, Runny nose, Sneezing, Stuffy Nose, Watery Eyes
Genitourinary	Blood inUrine, Burning, Excessive Urination, Flank Pain, Infection, Kidney Stones, Retention, Urgency, Incontinence
Eye	Blurred Vision, Cataracts, Contacts, Eyeglasses, Glaucoma, Infection

Eddie P. LO, DPM and Natalie T. Chu. DPM, PLLC

Insurance Waiver and Permissions

PERMISSION IS GIVEN TO **DR. LO AND DR. CHU TO RENDER THE PROPOSED PODIATRIC EXAMINATION AND TREATMENT.
**I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE UNDERSIGNED PHYSICIAN FOR SERVICES RENDERED.
**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FPR NON-COVERED SERVICES.
**IF THERE ARE ANY QUESTIONS ON FEES, PLEASE ASK PRIOR TO ANT PROPOSED EXAMINATION OR TREATMENT, AS IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES AT THE TIME OF THE VISIT. ALL OTHER ARANGEMENTS MUST BE MADE IN ADVANCE WITH THE DOCTOR.
Our billing staff will happily bill your insurance carrier(s) for your services today: however, you may be billed for your visit if ANY of the following apply:

1. Treatment is not covered or not deemed medically necessary by your insurance plan.
2. Your insurance is pending and not guaranteed to be in effect at time of service.
3. You have no insurance and wish to pay for today’s services out of pocket.
4. Your insurance deductible has not been met.

By signing below you agree that you understand and accept financial responsibility for today’s services and future services (including doctor’s fee, lab, fees, etc.) up to $1000.00 per visit.
In the event of default of payment and /or failure to pay, you agree to pay all costs of collection including court costs and reasonable attorney fees to be determined by a court of law. If suit is commenced to enforce the terms of this agreement, the court of the State of Washington and federal court located in the State of Washington shall have personal jurisdiction over the patient, and the venue of suit, at the option of Dr. Eddie Lo or Dr. Natalie Chu may be laid in Pierce County.

____________________________	____________________________	____________________
Print Name	**Sign Name**	**Date**
____________________________	____________________________	____________________
Witness Name	**Sign Name**	**Date**

Note: This waiver does not replace certain specialized insurance waivers including, but not limited to, the Medicare ABN and Notice of Non-Covered Services. Depending upon your insurance plan and the services being rendered today, additional forms may be required.

Health Insurance Portability and Accountability Act

We keep a record of the Health Care Services we provide you and are required by state and federal law to keep this information confidential. You may ask to see and receive a copy of that record. You may ask to correct that record. We will not disclose your records to others unless you direct us to do so in writing or unless the law authorizes or compels us to do so. You may not see your records or get more information about them by contacting our Medical Records Department.
Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access your information. It is available for view at all of our locations and you may receive a copy upon request.
By my signature below, I acknowledge I have reviewed Eddie P. Lo & Natalie T. Chu, PLLC’s
Notice of Privacy Practices and my questions and concerns have been addressed.

____

Patients Signature & Date
Representive Signature if Patient is Under 13 Years of Age Relationship to Patient
OPTION FOR RELEASE
Must be completed by all patients 13 Years of Age and older
****If option below is marked, patient must fill out an Authorization to Release Health Care Info****
I would like to allow access to my protected health care information as defined in the Notice of Privacy Practices to the following people. Without my permission, these people will not be granted verbal or written information regarding my protected health care information.
_______Spouse
_______Parent
_______Other Relationship to Patient______________________