DR. ANTHONY J. FEDRIGO, DPM, FACFAS
DR. OENDRILA KAMAL, DPM, AACFAS

PATIENT INFORMATION

TODAY'S DATE_____ YOUR NAME _____BIRTHDATE _____ M/F
YOUR ADDRESS _____ APT # _____
CITY _____ STATE _____ ZIP CODE_____
HOME PHONE _____ WORK _____ CELL _____
SS# _____
EMAIL ADDRESS _____

PLEASE LET THE STAFF KNOW IF YOU WOULD LIKE INFORMATION ON AN ADVANCED DIRECTIVE
PRIMARY CARE PHYSICIAN _____ CITY _____
PHONE NUMBER _____ DATE OF LAST VISIT _____

EMERGENCY CONTACT _____ PHONE _____
PARENT (if minor) _____

EMPLOYMENT STATUS: ( )FULL TIME ( )PART TIME ( )SELF ( )RETIRED ( )STUDENT
EMPLOYER _____ADDRESS _____

PRIMARY INSURANCE _____ POLICY ID # _____
NAME OF SUBSCRIBER _____ RELATIONSHIP _____
SUBSCRIBER BIRTHDATE _____ SUBSCRIBER SOCIAL SECURITY # _____
SUBSCRIBER ADDRESS (if different) _____
EFFECTIVE DATE _____ GROUP # _____ GROUP NAME _____

SECONDARY INSURANCE* _____ POLICY ID# _____
NAME OF SUBSCRIBER _____ RELATIONSHIP_____
SUBSCRIBER ADDRESS (if different) _____
EFFECTIVE DATE _____ GROUP# _____ GROUP NAME _____

***SECONDARY INSURANCE IS ONLY BILLABLE WITH MEDICARE PRIMARY**

_____

SIGNATURE

DR. ANTHONY J. FEDRIGO, DPM, FACFAS
DR. OENDRILA KAMAL, DPM, AACFAS

MEDICAL INFORMATION

PHARMACY _____ CITY _____ PHONE _____
WHO REFFERED YOU TO THIS OFFICE? _____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES AND/OR REACTION: (CHECK ALL THAT APPLY)

( ) LOCAL ANESTHIA ( ) ASPIRIN ( ) ANTIBIOTICS ( ) ADHESIVE TAPE
( ) TETANUS VACCINE ( ) TYLENOL ( ) PENICILLIN ( ) OTHER_____
( ) SULFA DRUG ( ) CODEINE ( ) CORTISONE ( ) REACTION_____
( ) STATINS ( ) VICODIN ( ) IODINE

PL

FD

MEDICAL INFORMATON

WHAT AND WHERE IS YOUR PRESENT PROBLEM? _____
HOW LONG HAS IT BEEN BOTHERING YOU? _____ WHAT MAY HAVE CAUSED IT? _____
HAVE YOU HAD ANY PREVIOUS TREATMENTS? _____ ANY OTHER CONCERNS? _____

HAVE YOU HAD INJURIES TO YOUR: ( )FEET ( )ANKLES ( )KNEES ( )HIPS ( )BACK **(CHECK ALL THAT APPLY)**
DO YOU GET NUMBNESS IN YOUR: ( )FEET ( )LEGS ( )HIPS ( )BACK ( )HANDS ( )ARMS **(CHECK ALL THAT APPLY)**

SHOE SIZE: _____ WEIGHT: _____ HEIGHT: _____ LAST BLOOD PRESSURE (IF KNOWN) _____ /_____
DAILY EXERCISE _____
DO YOU CURRENTLY USE TOBACCO? NO / YES If yes, how long? _____ Quit?_____ Years Ago? _____

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL PROBLEMS? _____
HOSPITALIZATIONS/SURGERIES? _____
FAMILY HISTORY MEDICAL CONDITIONS? _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS (CHECK ALL THAT APPLY)

( ) HIGH BLOOD PRESSURE	( ) DVT/PHLEBITIS	( ) ARTHRITIS	( ) ASTHMA	( ) HEPATITIS
( ) ATRIAL FIBRILLATION	( ) VARICOSE VEINS	( ) GOUT	( ) THYROID CONDITION	( ) KIDNEY
( ) HEART DISEASE	( ) ANEMIA	( ) LOW BACK PAIN	( ) SEIZURES	PROBLEMS
( ) STROKE	( ) BLEEDING DISORDER	( ) HISTORY OF CANCER	( ) AIDS/HIV	( ) ULCERS
( ) BLOOD CLOTS	( ) RHEUMATIC FEVER	( ) OTHER_____		( ) DIABETES 1/2

DATE: _____ **SIGNATURE:** _____

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PHONE: 415-461-6555 FAX: 415-461-6556

1704 NOVATO BOULEVARD
NOVATO CALIFORNIA 94947
PHONE: 415-331-4500 FAX: 415-331-9035

IT IS OUR RESPONSIBILITY TO NOTIFY YOU OF LAWS REGARDING PATIENT PRIVACY AND PROCEDURES IN EFFECT. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU WOULD LIKE US YOU PROTECT IT. PLEASE REVIEW IT CAREFULLY.

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND EACH STATEMENT.

_____ I AM AWARE THAT THE NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR ME TO READ HERE IN THE OFFICE, AND I MAY RECEIVE A COPY UPON MY REQUEST.

_____I AM AWARE THE STAFF WILL IDENTIFY THEMSELVES AS A DOCTOR'S OFFICE WHEN CONFIRMING APPOINTMENTS, RETURNING MY CALLS FOR A ROUTINE FOLLOW UP CALL. I FURTHER UNDERSTAND ANY MESSAGE LEFT FOR ME WILL NOT INCLUDE TEST RESULTS OR OTHER IDENTIFIABLE MEDICAL INFORMATION, UNLESS PREVIOUSLY REQUESTED BY ME.

_____ I AM AWARE THAT THE DOCTORS MAKE IT A PRACTICE TO KEEP MY PRIMARY CARE AND OR SPECIALITY PHYSICIANS NOTIFIED OF MY PROGRESS BY SENDING A REPORT DETAILING MY INITIAL VISIT AND/OR SUBSEQUENT VISITS AS HE MAY CONSIDER NEEDED.

_____ I AUTHORIZE THE DOCTORS AND THEIR STAFF TO RELEASE PERTINENT INFORMATION TO ANY PHYSICIAN OR PROVIDER THEY REFER ME TO FOR FUTURE CARE.

_____ I AUTHORIZE THE FOLLOWING PERSON _____ TO HAVE ACCESS TO MY MEDICAL INFORMATION, INCLUDING TESTS, SCHEDULED APPOINTMENTS AND BILLING.

_____ THIS INFORMATION IS IN EFFECT IMMEDIATELY AND SHALL REMAIN IN EFFECT UNTIL I GIVE FURTHER NOTICE.

_____ I AM AWARE THAT ITEMS MAY BE DISPENSED TO ME WHICH MAY NOT BE COVERED BY MY INSURANCE, SUCH AS: CRUTCHES, SURGICAL SHOES/BOOTS, WHEELCHAIR, KNEE WALKER, DRESSING MATERIALS AND BANDAGES, ALL COLLECTIVELY CALLED DME (DURABLE MEDICAL EQUIPMENT).

SIGNATURE _____ **DATE** _____

PRINT NAME _____