PODIATRIC REGISTRATION AND HISTORY

Patient Information Today's Date:_____

Patient Name: _____
Address: _____
City, State, Zip: _____

Birthdate: _____ **(month / day / BIRTH YEAR)**
Sex: ☐M ☐F Age _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient SS#: _____

Occupation: _____
Employer: _____

Spouse's Name: _____
Spouse's Birthdate: _____ Spouse's SS#: _____
Spouse's Occupation: _____
Spouse's Employer: _____
Whom may we thank for referring you? _____

Contact Info

Home: _____ Work: _____ Cell: _____
Email Address: _____
Best time and method to reach you: _____

IN CASE OF EMERGENCY, CONTACT
Name: _____ Relationship: _____
Home: _____ Work: _____ Cell:_____

Insurance

Primary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Date of birth of subscriber: _____ **(month / day / BIRTH YEAR)**

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Kemp all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Kemp to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature: _____ Date: _____
Relationship to patient: _____

PATIENT HEALTH HISTORY

Today's Date: _____

Patient Name: _____

Birthdate: _____ **(month / day / BIRTH YEAR)** Age: _____

Height: _____ Weight: _____ Shoe Size: _____

Name of Primary Care Physician: _____ Date last seen: _____

Have you ever been to a Podiatrist before? Y / N

If yes, please list name: _____ Last visit: _____

What foot or ankle problems are you having? _____

_____

When did the problem start? _____ Was it due to an injury? Y / N

List any prior professional care you received for this issue: _____

_____

List all medications that you currently use, or provide a copy of your medication list: _____

_____

List any allergies you have to medication: _____

List any surgeries you have had in the past with approximate dates: _____

_____

Do you have a family history of:

[ ] Diabetes [ ] Cancer [ ] Heart Disease [ ] High Blood Pressure [ ] Stroke

Do you smoke? Y / N packs per day? _____ Do you drink alcohol? Y / N Drinks per day? _____

Please check any conditions that you have or have had in the past:

[ ] High Blood Pressure	[ ] Diabetes	[ ] Chronic Infections
[ ] Heart Disease	[ ] Hypo/Hyperthyroidism	[ ] Rheumatic Fever
[ ] High Cholesterol	[ ] Kidney Disease	[ ] Tuberculosis
[ ] Lung Problems	[ ] Liver Disease	[ ] Hepatitis
[ ] Stroke	[ ] Stomach Problems	[ ] HIV / AIDS
[ ] Seizures	[ ] Cancer: type? _____	[ ] Anxiety
		[ ] Depression

[ ] Other condition(s) not listed: _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge.
I give permission to Dr. Kemp to administer and perform such procedures as may be deemed necessary
In the diagnosis and/or treatment of my condition.

Patient's Signature: _____ Date:_____

Tuyen Huynh Kemp, DPM

Podiatric Medicine & Surgery
Board Certified, ABPM

905 Fremont St, Santa Clara, CA 95050, (408)246-8840

I, _____, understand that as a member of my insurance plan, I may be billed for any co-payment, deductibles, non-covered services, or any patient balance that I may incur due to services rendered at Dr. Kemp's office.

Signature: _____ Date: _____

Please refer to your insurance card for applicable information.

Tuyen Huynh Kemp, DPM

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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 and understand the notice.

Printed Name: _____

Signature: _____ Date: _____