Welcome to Our Office

J.E. McCann, DPM
26800 Crown Valley Parkway Ste 485
Mission Viejo, CA 92692
949-364-5180

Patient Information

Last Name _____ First Name _____ Initial _____

Name You Go By _____ Age _____ Date of Birth _____/_____/____ Sex: M ☐ F ☐

Street_____ City_____ State _____ Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Social Security # _____Driver's License # _____ Marital Status: M ☐ S ☐ W ☐ D ☐

Employer _____ Occupation _____

Street_____ City_____ State _____ Zip _____

Emergency Contact #_____ Name & Relationship _____

Referring Information

Who may we thank for referring you? _____

Family Doctor _____Previous Podiatrist_____

What is your chief foot complaint? _____

Insured Person or Subscriber (if other than above)

Last Name _____ First Name _____ Initial _____

Date of Birth _____/_____/____ Age_____ Sex: M ☐ F ☐

Home Phone ( ) _____ Cell Phone ( ) _____ Business Phone ( ) _____

Social Security # _____Driver's License # _____

Employer _____ Occupation _____

Street_____ City_____ State _____ Zip _____

Insurance Information (If you have your insurance card you can skip this section)

Primary Insurance_____ Group # _____

Street_____ City_____ State _____ Zip _____

Insured Name _____ ID#_____

Eligibility Waiver

I authorize my insurance company to pay any and all charges rendered on my behalf directly to J.E. McCann, DPM. I will be responsible for and will guarantee payment on any and all charges which may not be paid or covered by my insurance company. I certify that the information given, including insurance coverage is complete and correct. I understand I may be charged $50 if I fail to show up for my appointment or cancel my appointment within 24 hours.

Signature: _____ Date: _____

Email: _____

Your email address will never be shared without your permission but will be used for communication from the office

Medical History

What is your foot problem?

_____

_____

When did problem begin? _____ Date (if an injury): _____

Describe any accident/event _____

Previous X-rays? ☐ Yes ☐ No Previous MRI? ☐ Yes ☐ No Previous CT? ☐ Yes ☐ No

Describe any previous treatment or home remedies _____

Have you ever had foot surgery? ☐ Yes When and by whom? _____

Are you here for a: ☐ Consultation ☐ Surgical Evaluation ☐ Second Opinion ☐ Workers Compensation Evaluation

Do you have or have you ever been treated for:

Diabetes I or II	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No
Problems Healing	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV	☐ Yes	☐ No

List other health problems: _____

_____

_____

_____

Height: _____ Weight: _____

How much are you on your feet at work?

☐20% ☐40% ☐60% ☐80% ☐100%

Do you smoke? ☐Yes packs per day ____ ☐No

Do you drink alcoholic beverages?

☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

List any sports/activities: _____

Allergies to Medications or Materials:

Antibiotics (please list below)	☐ Yes	☐ No
Pain Medication (Codeine, Vicodin)	☐ Yes	☐ No
Local anesthetics	☐ Yes	☐ No
Adhesive tape	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Iodine	☐ Yes	☐ No

Type of reaction: _____

_____

Any Other Allergies: _____

_____

Do you take any of the following medications?

	Yes	No	Medication
Insulin	☐	☐	_____
Oral diabetic medication	☐	☐	_____
Blood thinner	☐	☐	_____
Heart medication	☐	☐	_____
Water pills	☐	☐	_____
Birth control pills	☐	☐	_____
Anti-depressant	☐	☐	_____

Please list other medications: _____

_____

_____

_____

Please list previous medical or surgical problems: _____

_____

If female, are you pregnant? Yes No

Preferred Pharmacy: _____ Phone Number: _____

Your Name: _____

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Privacy Practices and Consent

The Health Insurance Portability & Accountability Act of 1996 requires that all medical records and other individually identifiable health information used or disclosed by this office be kept properly confidential. The individual is also provided the right to request confidential communications or that a communication of protected health information (PHI) be made by alternative means.

I wish to be contacted in the following manner (circle all that apply):

1. Home/Cell Telephone _____
    a. OK to leave message with spouse
    b. OK to leave message with detailed information
    c. Leave message to call the office only
2. Work Telephone_____
    a. OK to leave message with detailed information
    b. Leave message to call the office only
3. Written Communication
    a. OK to mail to my home address
    b. OK to mail to my work or office address
    c. OK to fax to this number _____
    d. OK to exchange information with referring doctors and treatment facilities
4. Other _____

_____ _____
Patient or Guardian Signature Date

_____ _____
Print Name Birth Date

I authorize your office to disclose my health information to the following people if needed

1. _____

2. _____