Susan S. Hiraoka, DPM, LLC

FOR OFFICE USE ONLY			
Account #	**TYPE**	**DR. #**	**DATE**

Last Name:	First Name:	Middle Initial:	Gender:
Age:	Date Of Birth:	Social Security:	Marital Status: __single __ married __ divorced __ widowed __separated
Physical Address (include city, state, and zip code):			
Mailing Address If different from above (include city, state, and zip code):			
Email Address:	Home Phone:	Cell Phone:	Work Phone:
Employer name/address:			Business Phone:
Emergency Contact Name:	Relationship:		Phone:
Primary Care Physician:			Phone:
Referring Physician:			Phone:

IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING

Parent/Guardian's Name:	Relationship to patient:		
Home Phone:	Business Phone:	Cell Phone:	Child's School:
Person(s) who may Authorize treatment for Child:		Relationship to Patient:	

INSURANCE INFORMATION

Guarantor's Name/Address:			Phone:
__ Private Insurance	__ Worker's Compensation	__ No-Fault	__ TPL

Primary Insurance				
	Carrier	Subscriber Name	Relationship to Subscriber	Subscriber DOB
Secondary Insurance				
	Carrier	Subscriber Name	Relationship to Subscriber	Subscriber DOB
Third Insurance				
	Carrier	Subscriber Name	Relationship to Subscriber	Subscriber DOB

Race:

	Asian		Black/African American		Hispanic		Caucasian		Pacific Islander
	Alaska Native		American Indian		Other:				
Preferred Language:									

Authorization to Release Medical Information and Assignment of Insurance Benefits:
I authorize SUSAN S. HIRAOKA, DPM, LLC its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

Financial Agreement: I understand that I am financially responsible for all charges whether or not paid by said insurance. These include deductible, cost-share, and/or non-covered benefits.
I certify that the insurance information provided is correct. I permit a copy of this authorization to be used in place of the original.
This Authorization is valid until revoked by me in writing.

_____ _____

Signature **Date**

Medical History and Patient Questionnaire Sheet

Please check all that apply:

	Diabetes		Cardiovascular Disease		Kidney Disease
	Cancer type:		Thyroid Disorder		Arthritis type:
	Asthma		Jaundice/Liver Problem		Tuberculosis
	High Cholesterol		High Blood Pressure		Stomach Ulcer
	Stroke		Gout		Circulation Problem
	Other:				

Family History:

Mother:

	Diabetes		Cardiovascular Disease		Kidney Disease
	Cancer type:		Jaundice/Liver Problem		Arthritis type:
	High Cholesterol		High Blood Pressure		Circulation Problem
	Stroke		Gout		Deceased
	Other:				

Father:

	Diabetes		Cardiovascular Disease		Kidney Disease
	Cancer type:		Jaundice/Liver Problem		Arthritis type:
	High Cholesterol		High Blood Pressure		Circulation Problem
	Stroke		Gout		Deceased
	Other:				

Siblings: B= Brother S= Sister

	Diabetes		Cardiovascular Disease		Kidney Disease
	Cancer type:		Jaundice/Liver Problem		Arthritis type:
	High Cholesterol		High Blood Pressure		Circulation Problem
	Stroke		Gout		Deceased
	Other:				

Have you ever smoked cigarettes?

	Never		Current Every Day		Current Some Day		Former Smoker
Start Date:					Quit Date:		

Please Check All That Apply:

	Flu Vaccine	Date:		Mammography Screening	Date:
	Pneumonia Vaccine	Date:		Colorectal Screening	Date:
	Eye Exam/Screening	Date:			

	COVID VACCINE	Dose 1	Dose 2	Dose 3
Pfizer		Date:	Date:	Date:
Moderna		Date:	Date:	Date:
J & J		Date:	Date:	Date:

Previous Surgeries: _____

_____

Medical History and Patient Questionnaire Sheet

Please List all Medication and doses:

Medication	Dose	Medication	Dose	Medication	Dose

Preferred Pharmacy:		
Height:	**Weight:**	**Shoe Size:**

Please List any Allergies:

FOOD:	
MEDICATION:	
OTHER:	

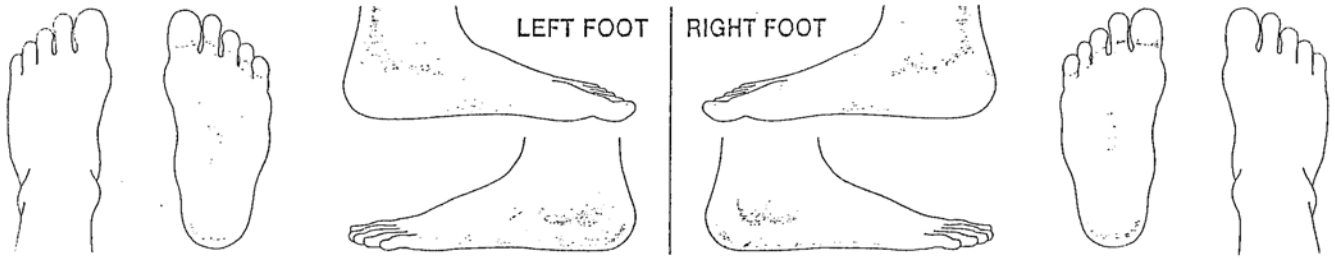
Please indicate in the diagram and in a few brief words, what is your foot or ankle problem:

_____

_____

_____

_____



How long have you had this problem? _____

Susan S. Hiraoka, DPM, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to patient:

We are required to offer you for review and/or a copy of our Notice of Privacy Practices which state how we may use and/or disclose your health information. Please sign this form to acknowledge review of Notice.

I acknowledge that I have reviewed and/or been offered a copy of this office's Notice of Privacy Practices.

Patient:

Name:	Date of Birth:

_____ _____

Signature Date

Parent or Authorized Representative:

Name:	Date of Birth:

_____ _____

Signature Date

HIPAA Acknowledgement of Receipt of the Notice of Private Practices