Central Valley
Surgical Specialists

PATIENT INFORMATION

Patient Name: _____ M / F Email: _____

Address:_____City:_____ Zip:_____

Date Of Birth: _____ Age:_____ Ethnicity (optional):_____ Language:_____

Phone Number: (Cell)_____ (Work) _____

Referring MD:_____ Phone:_____

Primary Care: _____ Phone:_____

Is you visit related to an accident or work related injury: Y / N

How were you injured? Please describe:_____

Employer:_____ Social Security # _____

Employer Address _____ Phone Number _____

INSURANCE INFORMATION:

Policyholder's Name _____I.D._____ D.O.B. _____

Relationship to patient: _____

If no one is home, whom do you authorize us to contact in case of emergency?

Name: _____ Phone:_____ Relationship: _____

PLEASE GIVE ALL CARDS TO RECEPTIONIST FOR COPYING

ASSIGNMENT OF BENEFITS:

I hereby assign all Medical and/or Surgical Benefits, to include Major Medical Benefits to which I am entitled,(including Medicare, Medi-Cal, Private insurance and any other health plan) to **Anthony S. Nguyen, DPM** for all charges, whether or not they are paid by said insurance, I authorize Anthony S. Nguyen, DPM to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services. A photocopy of this assignment is to be considered as valid as an original.

I further authorize Anthony S. Nguyen, DPM to furnish my insurance company all medical information which the insurance company may request for the evaluation of claims. I also authorize the release of my referring physician records concerning my illness or injury.

Patient or Guardian Signature: _____Date: _____

Central Valley Surgical Specialists

PATIENT HISTORY

Patient Name: _____ **Date of Birth:** _____

SOCIAL HISTORY:

Marital Status: Married Single Divorced/Window Job History: Working Retired Student

Do you currently smoke? Y / N If yes, for how long (Packs per day) _____

Have you smoked before? Y / N If yes , for how long (Packs per day) _____

Alcohol: Y / N If yes, how many drinks per week? _____

Drugs: Y / N If yes what kind? _____

PAST MEDICAL HISTORY: (circle all that apply)

CVS: Hypertension Heart Attack Stroke Irregular Heart Beat Heart Failure Valve Disease Weak Leg Circulation

PULM: Asthma COPD/Emphysema Valley Fever Home Oxygen Needs

GI: Peptic Ulcer Reflux/heartburn Liver Disease/Jaundice Gallbladder Disease Hiatal Hernia Chron's Disease/Colitis

RENAL: Kidney Failure Kidney Stones Urinary Retention

ENDOCRINE: Diabetes Hypothyroidism Parathyroid Disease High Cholesterol

MUSCU: Arthritis Osteoporosis Rheumatoid Arthritis

HEMO: Excessive Bleeding Blood Clots Anemia

PSYCH: Depression Anxiety Bipolar

SKIN: Melanoma Skin Cancer Dermatitis/Eczema

OTHER: _____

Do you have a history of excessive bleeding after a surgical procedure? Yes _____ No _____

Do you take any of the following: Aspirin ___ Plavix ___ Coumadin ___ Eliquis ___ Xarelto ___

HOSPITALIZATIONS/SURGERIES:

Type of surgery: Hospital: Year (Approximate):

_____

_____

_____

_____

FAMILY MEDICAL HISTORY: (Please list any significant medical history in family)

Do you have any of the following in your family? Circle the ones that apply.

Diabetes Hypertension Heart Disease Cancer _____

CONDITION: FAMILY MEMBER:

_____

_____

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Patient Name: _____ **Date of Birth:** _____

ARE YOU ALLERGIC TO ANY MEDICATION(S)?

Name of Medication:	**Type of Reaction:**
_____	_____
_____	_____
_____	_____

PLEASE PROVIDE A LIST OF CURRENT MEDICATIONS AND THEIR DOSES.
THIS INCLUDES OVER-THE-COUNTER MEDICATIONS, HERBAL SUPPLEMENTS AND VITAMINS.

	MEDICATION:	**DOSAGE:**	**FREQUENCY:**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

ARE YOU ALLERGIC TO: **IV CONTRAST** **LATEX** **TAPE**

PHARMACY: _____ **PHARMACY NUMBER:** _____

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Consent for purposes of treatment, payment and healthcare operations by Anthony S. Nguyen, DPM

I consent to the use or disclosure of my Protected Health Information by Anthony S. Nguyen, DPM. For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by Anthony S. Nguyen, DPM. I understand the diagnosis or treatment of me by Anthony S. Nguyen, DPM may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Anthony S. Nguyen, DPM is not required to agree to the restrictions that I may request. However, if Anthony S. Nguyen, DPM agrees to a restriction that I request, the restriction is binding on Anthony S. Nguyen, DPM.

I have the right to revoke the consent, in writing, at any time, except to the extent that Anthony S. Nguyen, DPM has take action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review Dr Nguyen's Notice of Privacy Practices prior to signing this document. Dr Nguyen's Notice of Privacy Practices has been provided to me. The information will include my treatment, payment of my bills or in the performance of health care operations by Dr. Anthony Nguyen. The Notice of Privacy Practices for Anthony S. Nguyen, DPM is also provided in the waiting room of his office, 9610 Stockdale Highway, Suite D, Bakersfield Ca. 93311. This Notice of Privacy Practices also describes my rights and Dr. Nguyen's duties with respect to my Protected Health Information.

Dr. Anthony S. Nguyen, DPM reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature: _____ **Date:** _____