

**Dr. Efren "Buff" De La Rosa  
Podiatrist  
Patient Intake Form**

**Patient**

Date _____	_____
Last Name _____	DOB _____
First Name _____	SS # _____
Address _____	Employer _____
City _____	Occupation _____
State/Zip Code _____	Referred by _____
Home Phone No _____	Emergency _____
Work Phone No _____	Contact _____

**Responsible Party (Who is financially responsible for this bill?)  
MUST BE FILLED OUT COMPLETELY**

Last Name _____	DOB _____
First Name _____	SS # _____
Address _____	Employer _____
City _____	Address _____
State/Zip Code _____	City _____
Home Phone No _____	State/Zip Code _____
Work Phone No _____	Relationship to Patient _____

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**Primary Insurance**

Name of Insurance \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State/Zip Code \_\_\_\_\_  
Phone No \_\_\_\_\_  
Insured ID # \_\_\_\_\_

**Secondary Insurance**

Name of Insurance \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State/Zip Code \_\_\_\_\_  
Phone No \_\_\_\_\_  
Insured ID # \_\_\_\_\_

**Payment Policy**

All services rendered are the financial responsibility of the patient or the patient's parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

**Authorization of Payment**

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered.

Signed \_\_\_\_\_

# Efren De La Rosa, DPM

## Patient Medical History

### General Data

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Sex \_\_\_ M \_\_\_ F Are you pregnant \_\_\_\_\_ If so, how many months \_\_\_\_\_

### Medical History

Last Physical Exam \_\_\_\_\_

Family Doctor \_\_\_\_\_

Hospitalization/Surgeries \_\_\_\_\_

\_\_\_\_\_

Past & Present Medications \_\_\_\_\_

\_\_\_\_\_

Allergies to Medications \_\_\_\_\_

\_\_\_\_\_

Recent Weight Loss \_\_\_\_\_

Bleeding Tendencies \_\_\_\_\_

Scarring Tendencies \_\_\_\_\_

Stomach Ulcers \_\_\_\_\_

Heart Problems \_\_\_\_\_

Arthritis \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Lung Problems \_\_\_\_\_

Kidney/Liver Problems \_\_\_\_\_

Diabetes \_\_\_\_\_

Blood Clots in Legs \_\_\_\_\_

Joint Implants \_\_\_\_\_

Circulation Problems \_\_\_\_\_

HIV Positive \_\_\_\_\_

Smoke \_\_\_\_\_ How much \_\_\_\_\_

Alcohol \_\_\_\_\_

Past or Present Use of Illegal Drugs \_\_\_\_\_

Other Medical Problems \_\_\_\_\_

Family History of Medical Problems \_\_\_\_\_

Information Taken By \_\_\_\_\_

Date \_\_\_\_\_

### Chief Complaint

\_\_\_\_\_

\_\_\_\_\_

When or How Long \_\_\_\_\_

Type of Pain \_\_\_\_\_

Previous Treatment \_\_\_\_\_

\_\_\_\_\_

Job Related? \_\_\_\_\_

Whom may we thank for referring you to our office or how did you first hear of us? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reviewed by Dr. (Initials) \_\_\_\_\_

## **Agreement/Conditions of Treatment**

This is an agreement between Dr. Efren De La Rosa and me, summarizing our discussion and understanding of the conditions under which I consent to treatment of my foot/ankle problems.

I understand that my physician, Dr. De La Rosa, will use his best skill and judgment to accomplish the desired result, but that Dr. De La Rosa cannot and does not warrant or guarantee such result; also that his forecast of the length of time involved in therapy and/or recovery from surgery, the manner of recovery and the possible complications or untoward results is based upon the usual and average response in cases similar to mine, but that it is not a promise, since my result/response may be different from the usual.

On my part, I promise full cooperation with Dr. De La Rosa and his staff in my treatment, whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions, or the instructions of his staff, concerning my care and treatment, including any necessary physical therapy, the outcome of my care and treatment could be put into jeopardy and a bad result may occur.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_