ADAM DUSTIN, D.P.M.
SAM SPENCER, D.P.M.
COLLIN SMITH, D.P.M.
326 Encinitas Blvd, Suite 100
Encinitas, CA 92024
Phone: (760) 436-5533 Fax: (760) 436-0611

Registration Information

Patient Information

Patient Name _____ Today's Date _____

Social Security Number _____ Address _____

Date of Birth _____ Age _____ Apartment/Suite _____

Primary Phone _____ City _____

Email Address _____ State _____ Zip _____

Patient Employment Information

Employer _____ Position _____

Business Address _____ Business Phone _____

Spouse/Parent Information

(If the patient is under 18 years of age, please provide parent/guardian information below)

Spouse/Parent Name _____ Relation _____

Spouse/Parent SSN _____ Spouse/Parent Phone _____

Spouse/Parent Employer _____ Employer Phone _____

Emergency Contact

☐*(Please check this box if the designated emergency contact is the spouse or parent listed above)*

Emergency Contact _____ Emergency Contact Phone _____

Whom may we thank for referring you? _____

Insurance Information

Insurance Information (Please fill out subscriber information only if the patient is not the policy subscriber)

Primary Company _____ ID# _____

(Please fill out subscriber information only if the patient is not the policy subscriber)

Subscriber Name _____ DOB _____ SSN _____

Subscriber Address _____

I certify that the above information is accurate and complete. I understand that I am personally responsible for payment of all fees incurred, and payment of fees is required at the time of service unless prior arrangements have been made. In the event of nonpayment, I agree to bear the cost of collection, court costs, and/or legal fees. I authorize Dr. Dustin and/or Dr. Spencer to release information for the treatment of my condition, administration of my account or submission of insurance claims. I authorize my insurance company to send payment directly to Dr. Dustin and/or Dr. Spencer.

Patient (or Parent) Signature _____ Date _____

ADAM DUSTIN, D.P.M.
SAM SPENCER, D.P.M.
COLLIN SMITH, D.P.M.
326 Encinitas Blvd, Suite 100
Encinitas, CA 92024
Phone: (760) 436-5533 Fax: (760) 436-0611

Medical History

Please describe your foot and/or ankle problem: _____

_____

Primary Care Physician: _____ Phone: _____

Allergies to medications: _____
Please list current medications: _____

_____

Please check if you have ever been diagnosed or treated for any of the following problems:

❑ Arthritis
❑ Asthma
❑ Bladder Problems
❑ Bleeding Disorders
❑ Cancer
❑ Chlamydia/Reiter's Syndrome
❑ Diabetes Mellitus (Insulin-dependent: ❑ Yes ❑ No)
❑ Heart Attack
❑ Heart Problems
❑ Hepatitis B or C
❑ High Blood Pressure
❑ HIV/AIDS
❑ Kidney Problems
❑ Liver Problems
❑ Lung Problems
❑ Neurologic Problems
❑ Peripheral Neuropathy
❑ Thyroid Disease
❑ Seizure Disorder
❑ Stroke/TIA
❑ Other: _____

Please check if you have any of the following in your social health history:

❑ Alcohol Use ❑ Caffeine Use ❑ Illegal Drug Use

Smoking Status:
❑ Non-smoker ❑ Former Smoker ❑ Current Smoker
If yes, _____ packs per day for _____ years

Marital Status:
❑ Married ❑ Single ❑ Divorced ❑ Widowed

Employment Status:
❑ Employed ❑ Unemployed ❑ Retired ❑ Student

Race:
❑ Caucasian ❑ Black or African America ❑ Asian
❑ Decline to state ❑ Other:_____

Ethnicity:
❑ Hispanic/Latino ❑ Not Hispanic/Latino
❑ Decline to state ❑ Other:_____

Preferred Language: ❑ English ❑ Spanish ❑ Other

Height: _____ Weight: _____ Most Recent Blood Pressure: _____ / _____ mmHg or ❑Normal ❑High ❑Low

Date of most recent hospital stay: _____ Reason: _____

Date of last medical examination: _____ Reason: _____

Prior foot or ankle surgery? ❑No ❑Yes, please explain _____

I certify that the above information is complete and accurate. I hereby authorize Dr. Dustin and/or Dr. Spencer to administer treatment and to perform such minor operative procedures as deemed medically necessary in the diagnosis and/or treatment of my foot and/or ankle conditions. I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity if I so chose) and understand the notice. I consent to photography for identification, educational, and/or documentation purposes.

Patient (or Parent) Signature _____ Date _____

ADAM DUSTIN, D.P.M.
SAM SPENCER, D.P.M.
COLLIN SMITH, D.P.M.
326 Encinitas Blvd, Suite 100
Encinitas, CA 92024
Phone: (760) 436-5533 Fax: (760) 436-0611

Financial Policy

Your understanding of the following financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

1. As our patient, you are responsible for all authorizations and referrals needed to seek treatment in this office.
2. Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. We accept VISA, MasterCard, cash, and check.
3. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable time period, we will have to look to you for payment.
4. We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay at the time of service. If you have an insurance policy with a deductible of $1,000 or greater, you may be required to pay a portion of that deductible at the time of service.
5. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization for such service, you will be responsible for the complete charge.
6. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services being rendered.
7. You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
8. Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
9. There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee. If you have written a check that does not clear the bank, we will accept VISA, MasterCard, and cash for future visits to our office.

Patient (or Parent) Signature _____ **Date** _____

Medical Release (Optional)

If so desired, please indicate to which individuals, if any, we may release your information in a meaningful and specific fashion. Such individuals may include primary care physicians and/or family members.

I authorize Alvera Podiatry Group, via my signature at the bottom of this page, to release my entire medical record to the below listed individuals. This release of my medical records is to expire on _____.
Date

Authorized Representative _____ Relationship _____

Authorized Representative _____ Relationship _____

Authorized Representative _____ Relationship _____

I hereby certify that I have read and understand the financial policy. I understand that I will be responsible for the information within these policies, and I have had all questions regarding these policies answered. I certify that, if requested, I was given a copy of the financial policy for my records. I also authorize Alvera Podiatry Group to release my entire medical record to those individuals mentioned above in the manner mentioned above.

Patient (or Parent) Signature _____ **Date** _____