DANIEL M. KLEINER, D.P.M.
10201 MISSION GORGE ROAD, SUITE K
SANTEE, CA 92071

SUBSCRIBER INFORMATION:

Subscriber Name ____________________ Home Phone ____________________

Home Address ____________________ City, State ____________ Zip __________

Relationship to patient ____________________ Birth Date __________ SS# ____________________

Employer ____________________ Job Title/Occupation ____________________

Address ____________________ City, State ____________ Zip __________

Work Phone ____________________

PATIENT INFORMATION

Name ____________________ Marital Status ☐Single ☐Married ☐Widow ☐Divorce

Home Address ____________________ City, State ____________ Zip __________

Home Phone ____________ Cell Phone ____________ E-mail ____________________

Birth Date __________ Sex ☐Male ☐Female SS# ____________________ Age __________

Smoker ☐Yes ☐No Full Time Student ☐Yes ☐No Ethnicity ☐ Hispanic ☐ Non-Hispanic Race ____________

Employer ____________________ Job Title/Occupation ____________________

Address ____________________ City, State ____________ Zip __________

Work Phone ____________________ Other Contact number ____________________

INSURANCE INFORMATION

Primary Insurance Plan: ____________________

IPA/HMO Name ____________________ Effective Date __________

Subscriber ID# ____________________ Group # ____________________

Insurance Address ____________________

Insurance Phone # ____________________

Secondary Insurance Plan: ____________________

IPA/HMO Name ____________________ Effective Date __________

Subscriber ID# ____________________ Group # ____________________

Insurance Address ____________________

Insurance Phone # ____________________

Has Deductible been met ☐ Yes ☐ No Deductible Amount $____________________

Does your insurance require a co-payment? ☐ Yes ☐No If yes, what is the amount $____________________

Please give your co-payment to the receptionist.

Does your insurance require: ☐ Prior authorization? ☐Second opinions?
☐ Referring physician? ☐ Their billing form(s) or labels?

Note: PLEASE GIVE YOUR INSURANCE CARD/S, FORM, ETC. TO THE RECEPTIONIST ON YOUR INITIAL VISIT FOR COPYING.

"I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any claims."

____

Patient or Authorized Signature

I request payment of this claim and authorize payment of Medicare Benefits or other benefits be made directly to the physician for the services described: I AM AWARE THAT IF I DO NOT PROVIDE A 24-HOUR NOTICE TO CANCEL MY APPOITMENT, I AM SUBJECT TO A $25 "NO SHOW" FEE.

____

Insured Signature / Date (Complete Back Side →)

WHAT IS YOUR PRESENT FOOT PROBLEM? ____________________

____

HOW WERE YOU REFERRED TO OUR OFFICE? ____________________

NAME OF M.D. YOU REGULARLY SEE ____________________

PERSON TO CONTACT IN CASE OF EMERGENCY: ____________________

RELATIONSHIP ____________________ PHONE NUMBER ____________________

ADDRESS ____________________

MISCELLANEOUS INFORMATION ____________________

____

MEDICAL QUESTIONNAIRE

CARDIOLOGY	**YES**	**NO**	**DISEASES**	**YES**	**NO**	**GENERAL**	**YES**	**NO**
Heart Attack	☐	☐	Diabetes	☐	☐	Cancer/Tumors	☐	☐
Heart Murmurs	☐	☐	Kidney	☐	☐	Stomach problems	☐	☐
Arteriosclerosis	☐	☐	Liver	☐	☐	Arthritis	☐	☐
Stroke	☐	☐	Thyroid	☐	☐	Polio Meningitis	☐	☐
High Blood Pressure	☐	☐	Gout	☐	☐	Paralysis	☐	☐
Swelling hands/Feet	☐	☐	**PULMONARY**			Nerve Disorders	☐	☐
Anemia	☐	☐	Asthma	☐	☐	V.D. (Syphilis) (AIDS)	☐	☐
Dizziness/Fainting	☐	☐	Pneumonia	☐	☐	Skin Disease	☐	☐
Convulsions	☐	☐	Tuberculosis	☐	☐	**DISABLED**		
Rheumatic Fever	☐	☐	Other:	☐	☐	Physically	☐	☐
Scarlet Fever	☐	☐	____________			Mentally	☐	☐

HAVE YOU EVERY HAD A BLOOD TRANSFUSION? ☐YES ☐NO DATE: ____________________

ARE YOU TAKING ANY KIND OF DIURETIC? ☐YES ☐NO KIND: ____________________

ARE YOU NOW TAKING ANY KIND OF DRUGS OR MEDICATION? ☐YES ☐NO

WHAT ARE THEY? ____________________

ARE YOU ALLERGIC OR HAVE YOU EVER HAD A REACTION TO THE FOLLOWING:

	YES	**NO**		**YES**	**NO**		**YES**	**NO**
Penicillin	☐	☐	Anesthetics	☐	☐	Tape or	☐	☐
Antibiotics	☐	☐	Novocain	☐	☐	Band Aids	☐	☐
Codeine	☐	☐	Sulpha Drugs	☐	☐	Foods	☐	☐
Aspirin	☐	☐	Other: ____________			Plants/Animals	☐	☐

IF NO KNOWN DRUG ALLERGIES WRITE NONE: ____________________