Dr. Lorie Robinson, DPM

Podiatrists- Foot and ankle specialists

PATIENT INFORMATION

Last Name_____ First Name_____ Middle initial_____

Date of Birth_____ Age_____ Sex_____ SSN_____

Street Address_____ Apt#_____

City_____ State_____ Zip_____ Home Phone_____

Cell Phone_____ Work Phone_____

WHOM MAY WE THANK FOR REFERRING YOU

Newspaper / Website / Family / Friend / Physician / Other/ _____

Name_____

PRIMARY CARE PHYSICIAN

Dr._____ Date of last visit_____

Address_____ Phone_____

EMERGENCY CONTACT

Name_____Relationship_____ Phone_____

Advance Directive? YES / NO

PATIENT EMPLOYER INFORMATION

Occupation_____

Employer_____ Address_____

INSURANCE Please bring you insurance cards and ID to the front desk and you may leave this section blank.

Who is financially responsible for this account? _____

Primary insurance_____

Secondary insurance_____

Date of birth_____ Relationship to patient_____

Please turn over and complete the other side

5370 Hollister Ave. Suite 7

Goleta, CA 93111

(805)683-5674 Phone

(805)683-5673 Fax

Primary Concern today? _____ When did the problem start? _____

Where is the problem? Right / Left / Both _____

How have you treated this problem so far? _____

Have you seen another doctor for this problem? _____ If so, whom? _____

Medical Conditions (circle): Hypertension / Diabetes / Back Pain / Blood Clot or DVT / Stroke / Gout / Heart Disease

Kidney Disease / Liver Disease / Stomach Ulcer / Autoimmune Disease / HIV / Hepatitis / Other_____

ALLEGRIES _____

MEDICATIONS

_____

_____

Are you on blood thinners? YES / NO

Flu Shot? YES/ NO

Surgical history & year_____

Family history (circle): Diabetes / Stroke / Hypertension / Heart Disease / Gout / other_____

Parent's medical condition/ cause of death?

_____

Social history: Occupation_____ Strenuous activities_____

Smoker? Never/ Quit (history_____) / Current, amount & years_____

Please Circle all that apply:

Constitutional	**Eyes**	**ENT**	**Cardiovascular**	**Respiratory**	**Gastrointestinal**	**Genitourinary**
Nausea/vomiting	Double vision	Nose bleeds	Chest pain	Short of breath	Abdominal pain	Blood in urine
Chills	Visually impaired	Ear pain	Palpitations	Cough	Diarrhea	Discharge
Fever	Blind	Mouth pain	Murmur	Wheeze	Constipation	STDs
NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE	NEGATIVE

MSK	**Skin**	**Neurological**	**Psychiatric**	**Endocrine**	**Hematologic**	**Immunologic**
Rheumatoid	Skin	Headaches	Depression	Hyperthyroid	Anemia	Anaphylaxis
Nonambulatory	Condition	Stroke	Anxiety	Hypothyroid	Blood transfusion	Chronic infection
Stress fracture	Rash	Seizure/fainting	Substance abuse	Adrenal issue	NEGATIVE	NEGATIVE
NEGATIVE	Chronic sores	NEGATIVE	NEGATIVE	NEGATIVE		
	NEGATIVE					

Lorie Robinson DPM, FACFAS

FINANCIAL POLICY

Welcome to the office of Dr. Lorie Robinson

We accept Medicare, Anthem Blue Cross PPO, Blue Shield PPO and Cottage.

IF YOU HAVE SATISFIED YOUR DEDUCTIBLE, WE WILL ACCEPT YOUR COPAY AND BILL FOR YOUR SERVICE. IF YOU HAVE NOT SATISFIED YOUR DEDUCTIBLE, PAYMENT IS DUE AT THE TIME OF THE SERVICE.

For all other insurances, we will provide you with a superbill with the correct codes and diagnoses to be submitted to your insurance company for reimbursement.

Billing your insurance is not a guarantee of payment. You will receive a bill for your final balance after all applicable insurance payments are finalized.

NEW PATIENT VISITS: $145

ESTABLISHED PATIENT VISITS: $75-95

CUSTOM ORTHOTIC DEVICES $475

PROCEDURES VARY IN PRICE AND WILL BE DISCUSSED PRIOR TO PERFORMING.

Many Thanks for choosing our office for your care.

Signature:_____

Date:_____

Lorie Robinson DPM, FACFAS
5370 Hollister Ave, Suite 7
Goleta, Ca 93117
Phone 805-683-5674 Fax 805-683-5673

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Probability and Accountability Act of 1996(HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We required by law to maintain the confidentiality of your health information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate your request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or heath care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to: **Lorie Robinson DPM, FACFAS 5370 Hollister Ave #7 Goleta, Ca 93117** or contact the office **@805-683-5674** for further information.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our address. You must provide us with a reason that supports your request for an amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. Contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office receptionist for further information.

Signature:_____

Date:_____

Name of Patient:_____