

PILL HILL PODIATRY GROUP
400 30th Street, Suite 403
Oakland, CA 94609
Phone (510) 832-4197 Fax (510) 832-7340

Welcome to our office. Please complete the necessary information below. This information will be kept secure in this office. This office is HIPAA* compliant, and all information passed electronically follows state and national guidelines for your security.

Name _____ Gender M/F Date of Birth _____
 Social Security# _____ - _____ - _____ Single _____ Married _____ Divorced _____ Child _____
 Address _____ City _____ Zip Code _____
 Home Phone _____ Work Phone: _____ Alternate Phone _____
 Employer _____
 Subscriber of Insurance: Self/Spouse/Parent _____ Subscribers Date of Birth _____
 Insurance _____ Subscriber I.D. # _____
 Employer _____ Work Phone _____
 Emergency contact/relationship _____ / _____ Phone #: _____

Medical History:

Primary Care Physician _____ Date Last Seen _____
 Current Medications _____
 Allergies _____
 Recent Hospitalizations _____
 Previous Surgery _____

Do you have a history of

Heart Disease ___ High Blood Pressure ___ Arthritis ___
 Diabetes ___ taking insulin ___ pills ___ both ___
 Do you use tobacco ___ alcohol ___

I hereby authorize the Doctors to evaluate my podiatric condition and to perform any minor surgical procedures to treat said condition. I also authorize Pill Hill Podiatry to bill my insurance. I understand that I am responsible for all copayments and deductibles

Signature _____ Date _____

* Health Information Portability and Accountability Act