Eddie P. Lo, DPM and Natalie T. Chu, DPM, PLLC
1901 S. Union Ave Suite B4001, Tacoma, WA 98405
253-572-4848

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Sex: _____ Race: _____ Hispanic/Latino? Yes No
Language: _____ SSN: _____ Marital Status: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Pregnant: _____ Employment status: _____ Employer Name: _____
Employer Address: _____
Phone Number: _____ Work Phone: _____ Cell Phone: _____
Primary Care Physician: _____ Phone: _____
Email Address: _____ Referred By: _____
Height: _____ Weight: _____ Shoe Size: _____ Previous Podiatrist : _____

MAY OFFICE LEAVE DETAILED VOICE MAIL MESSAGES AT THE ABOVE LISTED NUMBERS?

Yes/ No Home Work Cell

Pharmacy Name: _____ **Pharmacy Location:** _____

- **Emergency Contact Information:**

Emergency First Name: _____ **Emergency Last Name:** _____
Phone: _____ **Relation to Patient:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

- **Primary Insurance:**

Name of Insurance: _____ **Identification Number:** _____
Subscriber: _____ **Group Number:** _____
Relation to Patient: _____ **Date of Birth:** _____

- **Secondary Insurance:**

Name of Insurance: _____ **Identification Number:** _____
Subscriber: _____ **Group Number:** _____
Relation to Patient: _____ **Date of Birth:** _____

- **GUARANTOR: (Person responsible for payment if not self)**

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Sex: _____ Address: _____
City: _____ State: _____ Zip: _____
SSN: _____ Marital Status: _____

WHAT PROBLEM BROUGHT YOU TO THE OFFICE? _____

Allergies: **Symptoms** **Severity**

_____ Mild Moderate Severe
_____ Mild Moderate Severe
_____ Mild Moderate Severe
_____ Mild Moderate Severe

Allergy to latex? Yes No

MEDICATIONS (Name, strength, dose): _____

Medical History	Yourself	Mother	Father
Arthritis			
Asthma			
Coronary Artery Disease			
Congestive Heart Failure			
COPD			
Cancer			
High Cholesterol			
Dementia			
Diabetes			
GERD			
Gout			
Headaches			
Hepatitis			
Hypertension			
MI (**Heart Attack**)			
Migraine			
Pneumonia			
Stroke			
TB			
Thyroid Disease			
Ulcer (GI)			
Other:			

Are you currently under CHEMOTHERAPY? Yes No

SOCIAL HISTORY:

Tobacco	No	Yes	Chewing Smoking: _____/Packs per day
Alcohol	No	Yes	Drinks per day: _____
Recreational Drugs	No	Yes	

PAST SURGERIES OF ANY TYPE?

_____

_____

_____

_____

REVIEW OF SYSTEMS: Please circle the symptoms that apply to you.

Head	Dizziness	Fainting	Headaches	Pain	Sweats
Nose	Bleeding	Discharge	Infections	Obstruction	
Mouth	Bleeding	Dentures	Dry Mouth	Post Nasal Drip	
Ear	Hearing Aid	Infection	Ringing		
Throat/Neck	Hoarseness	Lumps	Sore Throat	Tenderness	
Respiratory	Asthma	Bronchitis	Cough	COPD	
	Pleurisy	Short of breath	TB	Wheezing	
Cardiovascular	Chest Pain	Cramps in Legs/Feet	Extremity(s) Cool	Hair Loss on Legs	

	Heart Murmur	High Blood Pressure	History of MI	Leg or Foot Ulcer
	Palpations	Replacement of Heart Valve	Rheumatic Fever	Varicose Veins
	Vascular Grafts			
Gastrointestinal	Antacid Use	Constipation	Diarrhea	Excessive Thirst
	Gall Bladder Disease	Heartburn	Hemorrhoids	Hepatitis
	Jaundice	Laxative	Liver Disease	Nausea
	Rectal Bleeding	Swallowing Problem		
Musculoskeletal	Ankle Sprain	Arch Pain	Arthritis	Back Problems
	Childhood Foot Problem	Corns	Flat Feet	Gait (Walking) Problem
	Gout	Hammer/Mallet Toes	Heel Pain	High Arch Feet
	In-Toeing	Joint Pain	Joint Stiffness	Joint Implants
	Lower Back Pain	Muscle Cramps	Muscle Stiffness	Neuroma
	Orthotic Use	Paralysis	Restricted Motion	Shoe Insert Use
	Toe Walking	Weakness		
Psychiatric	Depression	Disorientation	Memory loss	
Skin	Athlete's Foot	Dryness	Eczema	Fungal Nails
	Hives	Ingrown Nails	Itching	Keloid Scar
	Lumps	Mole Changes	Rash	Warts
Neurological	Black Outs	Burning	Charcot Neuropathy	Fainting
	Neuroma	Numbness	Speech Disorders	Strokes
	Tingling	Tremors	Unsteady Gait	
Endocrine	Fatigue	Goiter	Sweats	Thirst
	Thyroid	Weight Gain	Weight Loss	
Hematologic/Lymph	Anemia	Bleeding Easily	Blood Clots	Easy Bruisability
	Recent Chemotherapy	Slow Healing Cuts	Swollen Glands	Transfusion Reaction
Allergic/Immunologic	Hives	Itchy Eyes	Itchy Nose	Runny Nose
	Sneezing	Stuffy Nose	Watery Eyes	Wheezing
	Swelling			
Genitourinary	Blood in Urine	Burning	Excessive Urination	Flank Pain
	Incontinence	Infection	Kidney Stones	Retention
	Urgency			
Eye	Blurred vision	Cataracts	Contacts	
	Eyeglasses	Glaucoma	Infection	

Eddie P. Lo, DPM and Natalie T. Chu, DPM, PLLC

Insurance Waiver and Permissions

PERMISSION IS GIVEN TO **DR. LO and DR. CHU TO RENDER THE PROPOSED PODIATRIC EXAMINATION AND TREATMENT.

**I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE UNDERSIGNED PHYSICIAN FOR SERVICES RENDERED.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

**IF THERE ARE ANY QUESTIONS ON FEES, PLEASE ASK PRIOR TO ANY PROPOSED EXAMINATION OR TREATMENT, AS IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES AT THE TIME OF THE VISIT. ALL OTHER ARRANGEMENTS MUST BE MADE IN ADVANCE WITH THE DOCTOR.

Our billing staff will happily bill your insurance carrier(s) for your services today; however, you may be billed for your visit if ANY of the following apply:

1. Treatment is not covered or not deemed medically necessary by your insurance plan.
2. Your insurance is pending and not guaranteed to be in effect at time of service.
3. You have no insurance and wish to pay for today's services out of pocket.
4. Your insurance deductible has not been met.

By signing below you agree that you understand and accept financial responsibility for today's services and future services (including doctor's fee, lab fees, etc.) up to $1000.00 per visit.

In the event of default of payment and/or failure to pay, you agree to pay all costs of collection including court costs and reasonable attorney fees to be determined by a court of law. If suit is commenced to enforce the terms of this Agreement, the Courts of the State of Washington and federal courts located in the State of Washington shall have personal jurisdiction over the patient, and the venue of suit, at the option of Dr. Eddie Lo or Dr. Natalie Chu may be laid in Pierce County.

_____	_____	_____
PRINT NAME	SIGN NAME	DATE
_____	_____	_____
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

Note: This waiver does not replace certain specialized insurance waivers including, but not limited to, the Medicare ABN and Notice of Non-Covered services. Depending upon your insurance plan and the services being rendered today, additional forms may be required.

Health Insurance Portability and Accountability Act

We keep a record of the Health Care Services we provide you and are required by state and federal law to keep this information confidential. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so in writing or unless the law authorizes or compels us to do so. You may see your records or get more information about them by contacting our Medical Records Department.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access your information. It is available for view at all of our locations and you may receive a copy upon request.

By my signature below, I acknowledge I have reviewed Eddie P. Lo, DPM & Natalie T. Chu, DPM, PLLC's **Notice of Privacy Practices** and my questions and concerns have been addressed.

_____

Patient's Signature Date

Representative Signature If Patient Is Under 13 Years of Age Relationship to Patient

OPTION FOR RELEASE

Must be completed by all patients 13 years of age and older

****If option below is marked, patient must fill out an Authorization to Release Health Care Info****

I would like to allow access to my protected health care information as defined in the **Notice of Privacy Practices** to the following people. Without my permission, these people will not be granted verbal or written information regarding my protected health care information.

_____ Spouse

_____ Parent

_____ Other Relationship to Patient _____