Dr. Andrew Cheng, DPM & Dr. Ricky Sukita, DPM

(808) 596-0305 | 405 N. Kuakini St. Suite 1111 Honolulu, HI 96817 | HawaiiFootDoc.com

Podiatric Medicine and Surgery

Demographics

Last Name________________________________ ☐Mr. ☐Mrs. ☐Ms. ☐Dr.

First Name________________________________ Marital Status ☐ Married ☐Single

Middle Initial______________________________ SSN____________________Gender ☐Male ☐Female

Occupation________________________________ Date of Birth_______________________________

Employed By____

Email Address ____

Address & Phone - *Please check your preference*

Full Address ______________________________ ☐Cell __________________________________

City_____________________________________ ☐Home_________________________________

State________________ ZIP________________ ☐Work__________________________________

Responsible Party ☐Self / ☐Other: Name____

Address______________________________ Phone_______________________________

Emergency Contact Name_____________________ Relationship________________Phone________________

Please list any members of your family that has been a patient here___________________________________

Referred by____

Primary Care Physician or Pediatrician___________________________________ Phone__________________

Insurance Information - *Please give the receptionist your insurance card(s) and photo ID to photocopy*

Primary Medical	Secondary Medical
Insurance______________________ Insured ID____________________________________	Insurance____________________ Insured ID____________________________________
Relationship to Subscriber	Relationship to Subscriber
☐Self ☐Spouse ☐Child	☐Self ☐Spouse ☐Child
Subscriber's Name_____________________________	Subscriber's Name____________________________
Subscriber's DOB_______________________________	Subscriber's DOB______________________________

Patient's Medical History: Please indicate if you have ever been diagnosed with the following medical conditions.

☐Diabetes 1 or 2 (circle one) ☐High Blood Pressure ☐Cholesterol ☐Thyroid Disease ☐Asthma ☐Arthritis/Osteoarthritis ☐Cancer ☐Stroke ☐Tuberculosis ☐Circulation ☐Jaundice/Liver ☐Heart Disease ☐Anticoagulants ☐Kidney Disease

Medications: ____

____

____

Allergies: ☐No ☐Yes - If yes, please list all drug, food and any other allergies you may have and your reaction

____

____

What is your main foot/ankle condition?____

☐ Right Foot ☐ Left Foot ☐ Both Feet ☐ Right Ankle ☐ Left Ankle ☐ Both Ankles

Duration/Start date?____

Describe your pain (circle): Sharp / Throbbing / Aching / Tingling / Burning / Numbness / Other __________

Surgical History?____

Family History?____

Social History: Please mark all that apply.

Tobacco Use/Smoking: ☐ No ☐ Yes - If so, for how long?______________

Alcohol Use: ☐ No ☐ Daily ☐ Weekly ☐ Monthly - If so, how many drinks per week?______________

Recreational Drugs: ☐ No ☐ Yes - If so, which ones and for how long?______________

Have you ever been to a Podiatrist before? ☐ No ☐ Yes - Physician's Name____________________

Preferred Pharmacy (Include city): ____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I assign my insurance benefits (HMSA, Medicare and/or any other medical insurance plan) payable to Hawaii Foot Doctor, Dr. Andrew Cheng, DPM. The assignment will remain in effect unless revoked by me in writing. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I further acknowledge that any insurance benefits, when received by and paid to Dr. Andrew K. Cheng will be credited to my account, in accordance with the above said assignment.

Patient or Legal Guardian Signature________________________________ Date____________________

Print Name________________________________ Relationship: ☐ Self / ☐ Other __________________

ACKNOWLEDGEMENT IN RECEIPT OF NOTICE OF PRIVACY PRACTICES FROM HAWAII FOOT DOCTOR: ANDREW K. CHENG, D.P.M. AND RICKY T. SUKITA, D.P.M.

I acknowledge that I had the opportunity to read if I so chose and/or provided a copy of the Notice of Privacy Practices.

Patient or Legal Guardian Signature________________________________ Date____________________

Print Name________________________________ Relationship: ☐ Self / ☐ Other __________________

NOTICE OF PRIVACY PRACTICES

TREATMENT: Your health Information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation. Your health Information may be disclosed to other physicians or health care providers (e.g. laboratory) who may be Involved in our care.

PAYMENT: Your health Information may be used to seek payment from your health plan. For example, your health plan may request and receive Information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day to day activities and management Hawaii Foot Doctor: Andrew Cheng, DPM and Ricky Sukita, DPM. For example, we use a sign-in sheet at the desk and your name will be called when the Doctor Is ready to see you.

LAW ENFORCEMENT AND PUBLIC HEALTH REPORTING: Your health information may be disclosed to law enforcement or government agencies to support government audits and inspections and to confirm compliance with government- mandated reporting. We are also required by the State Department of Health to report certain communicable diseases.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization.

PATIENT RIGHTS: You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and request copies of your protected health information.
4. The right to submit amendments/corrections to your protected health information. 5. The right to receive an accounting of how and to whom your protected health information has been disclosed

Our duties: We are required by Federal law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Print Patient Name________________________________

My _________________, ____ may have access to
(relationship) (name)
my medical records.

Witness: _________________ Patient Signature: __________________ Date: ________