Kevin A. Kirby, DPM and David M. Broderick, M.D.

Patient Information

Patient Name _____
First Middle Initial Last

Date of Birth _____Age_____Female/Male SSN _____

If Patient a Minor _____
Parents Name

_____
Employer Name Phone Number

Patient Address _____
Street City State Zip

Patient Phone _____
Home Work

Patient Employer _____
Name Address

Marital Status Married Single Divorced Widowed

_____
Spouse Name Phone Number

Emergency Contact _____
Name Phone Number

INSURANCE INFORMATION (If Applicable) **KAISER REFERRAL (If Applicable)**

Insurance Company Name:_____ **Kaiser Number:** _____
I.D. Number:_____ **Physician Name:** _____
Group Number:_____ **Location:** _____
Insured Name: _____
Relationship to Insured: Self Spouse Child Other

REFERRAL SOURCE

Referring Physician: _____ **Phone:** _____
Personal Referral: _____ **Phone:** _____
Facility Referral: _____ **Phone:** _____
Primary Care Physician: _____ **Phone:** _____

KEVIN A. KIRBY, D.P.M.
DAVID M. BRODERICK, M.D.

MEDICAL HISTORY

NAME:_____ **DATE:** _____

DATE OF ONSET OF INJURY OR SYMPTOMS: _____

MAIN PROBLEM: Please describe problem that requires evaluation today. _____

HISTORY OF PRESENT PROBLEM: How did this problem start or happen?

_____

_____

PAST MEDICAL HISTORY:

Any previous problems in this same area please describe and include dates.

_____

Please describe any fractures or other significant injuries you have had.

_____

Do you have any family history of serious diseases? (Heart Disease, Diabetes, Cancer, Arthritic problems, Birth Defects, etc.) Please describe.

_____

Please describe any previous surgeries, of any kind, which you may have had.

_____

Please describe any hospitalizations you may have had, excluding the above surgeries.

_____

Please list any medication you are allergic to and the reactions you have had.

_____

Please list any medications or nutritional supplements that you are currently taking.

_____

_____

Do you smoke? **Yes** **No** **If yes, how much?** _____

Do you drink alcohol? **Yes** **No** **If yes, how much?** _____

REVIEW OF SYMPTOMS: Please circle the appropriate responses and list any information in the space provided at the end of the review of symptoms.

RESPIRATORY: Do you have: Asthma, TB, Wheezing, History of Pneumonia, Other?

_____

CARDIOVASCULAR: Hypertension, Myocardial Infarction, Irregular Heartbeat, Other?

_____

GASTROINTESTIONAL: Do you have a history of: Nausea, Vomiting, Ulcers, Indigestion, Rectal Bleeding, Hepatitis, Weight Loss, Other? _____

GENITOURINARY: Have you had: Kidney Stones, Syphilis, Gonorrhea, Changes in Urinary Habits, Other? _____

ENDOCRINE: Do you have a history of: Diabetes, Thyroid Disease, Other? _____

NEUROMUSCULAR: Do you have a history of: Fractures, Congenital Anomalies, Arthritic Conditions Other? _____

PSYCHOLOGICAL: Do you have a history of: Psychiatric Disease or Treatment Yes No

NEUROLOGICAL: Do you have a history of: Seizures, Epilepsy, Tumors, Other? _____

Describe in detail, any of the above. _____

_____

_____

_____

OCCUPATION:_____**HOW LONG AT THIS OCCUPATION?** _____

Amount of time off work due to this injury/condition? _____

VITAL STATISTICS:

Height: _____ **Weight:** _____ **Age:** _____

Sex: Male Female Dominant Hand: Left Right

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form, I should ask the doctor or a member of the office staff for assistance.

_____ _____

Patient/Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Summary:

By, law, we are required to provide you with our **Notice of Privacy Practices (NPP)**. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of this Notice.

We want to assure you that your medical protected health information is secure with us. This Notice contains information about how we will insure that your information remains private. If you have any questions about this Notice, the name and phone number of our contact person is listed below.

Offices of Kevin A. Kirby, DPM & David M. Broderick, MD

Effective Date of this Notice:	**March 1, 2018**
Office Contact Person:	**Leslie Sanders**
Phone Number:	**(916) 925-8111**

Acknowledgement of Notice of Privacy Practices: "I hereby acknowledge that I have received a copy of this practice's **Notice of Privacy Practices**. I understand that if I have questions or complaints regarding my privacy right that I may contact the person listed above. I further understand that the practice will offer me updates to this **Notice** should it be amended, modified or changed in any way."

Acknowledgement of Medical Board Notice: "I hereby acknowledge that I understand that Medical Doctors are licensed and regulated by Medical Board of California. (800) 633-2322. www.mbc.ca.gov."

_____ _____

Printed Patient/Representative Name **Date:**

_____ _____**Patient Unable to Sign**

Patient/Representative Signature

_____**Patient Refused to Sign**