Christian R. Tolboe, DPM, FACFAS, CWS
David E. Paxton, DPM, AACFAS, MHA
Dallen S. Pope, DPM, AACFAS

TOLBOE Foot & Ankle

1401 Spanos Ct., Ste. 104, Modesto, CA 95355 Phone: (209) 525-3150 Fax (888) 491-3281

VERY IMPORTANT:

TO AVOID BEING CHARGED FOR CANCELLED OR MISSED APPOINTMENTS

In order to provide all of our patients the best care possible in a timely fashion, it is essential that we keep missed appointments to a minimum. When appointments are cancelled or missed without adequate notice, we cannot offer that time to other patients who are eager to be seen. Unfortunately, the increasing frequency of cancelled or missed appointments without enough notice requires that we implement the following policy:

POLICY FOR CANCELLED/MISSED APPOINTMENTS

There is a $25 missed appointment fee if you cancel or reschedule an appointment with less than 24-hour advance notice, or if you fail to arrive for your appointment. This fee is not billable to your insurance and is the patient's responsibility.

Please do not rely on our automated appointment reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service, or that the phone number provided is accurate or functional for this purpose. Please feel free to call at any point to confirm an appointment or to check on an upcoming date. The office phone number is (209) 525-3150.

Name of Patient: ___________________________________DOB: ______________
I have read and I understand the terms listed above in this policy.

Signature of Patient:______________________________Date: __________________
Signature of Parent or Guardian: ______________________ Date: ______________

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PATIENT INFORMATION:

Last Name: ______________________ First Name: _____________________MI: ____ ☐ Male ☐ Female

DOB: __________________ Age: ______ SSN: _______________________

Billing Address: _____________________________ City: _________________ State: _____ Zip: ___________

Street Address: ______________________________ City: _________________ State: _____ Zip: ___________

Home Phone: ____________________ Cell Phone: __________________ Work Phone: __________________

Email Address: ____ Preferred Phone: _______________________

Language Spoken: __________________ Ethnicity: ____________________ Marital Status: M S D W

Employer: ___________________ Employer Address: ____

INSURANCE INFORMATION:

Primary: _____________________ ID: _________________________ Group #: _______________________

Subscriber Name: _________________________ DOB: _______________ SSN: ________________________

Employer Name: ___________________________ Phone: ________________

Secondary: ____________________ ID: _________________________ Group #: _______________________

Subscriber Name: _________________________ DOB: _______________ SSN: ________________________

Employer Name: ___________________________ Phone: ________________

MINOR PATIENT:

Parent or Legal Guardian Name:____DOB:___________________
Mailing Address:____
Responsible Party Name:____Phone Number:___________

EMERGENCY CONTACT:

Name: _________________________________ DOB: ___________ Relationship: ______________________

Home Phone: ____________________ Cell Phone: __________________ Work Phone: __________________

PLEASE READ AND SIGN: I authorize Dr. Christian R. Tolboe, Dr. David E. Paxton, or Dr. Dallen S. Pope to furnish my insurance company or Medicare all necessary information regarding my present injury or illness. I also authorize payment of medical benefits directly to Tolboe Foot & Ankle, Inc. for any medical supplies or services rendered. I understand that I am financially responsible for all services. I understand that late fees will occur if my account is not paid in a timely manner. I understand that my account will be sent to collections when it is 120 days past due. It is understood that any overpayment will be reimbursed to me promptly. I authorize Dr. Christian R. Tolboe, Dr. David E. Paxton, or Dr. Dallen S. Pope to perform an examination, create a plan of care regarding my present foot and/or ankle injury or illness, and treat said injury or illness. A copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient: ____ Date: ____________
Signature of Responsible Party/Legal Guardian: _________________________________ Date: ____________

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PATIENT NAME: ______________________________________ **DATE:** ____________________

CHIEF COMPLAINT/PROBLEM AREA: ____

MEDICAL INFORMATION: Please circle and fill in blanks as necessary.

Current Weight: ________lbs. Height: _________

Have you had any surgeries in your life? ☐ Yes ☐ No

Type of Surgery: ____________________________ Year: ____________ Dr: ______________________

Do You Smoke? ☐ Yes ☐ No ☐ Former

If YES, how often: ___________________ If FORMER, how recent: _________________________

Do you drink Alcohol? ☐ Yes ☐ No If YES, how often: ____________________________________

Do you use recreational drugs? ☐ Yes ☐ No If YES, what kind and how often: _____________________

Allergies to Medication (NAME AND REACTION): ____

Are you allergic to Topical Iodine? ☐ Yes ☐ No Are you allergic to Latex? ☐ Yes ☐ No

Current Medications - NAME, DOSAGE, AND FREQUENCY:

____

____

____

____

What local Pharmacy Do You Use? Name: _______________________ Street: __________________________

Primary Care Physician: __________________ Phone: ____________ Date of Last Visit: ____________________

MEDICAL HISTORY:

Have you ever been told by a physician that you have (Please Check):

☐ Diabetes	☐ Kidney Problems	☐ Rheumatic Fever	☐ Arthritis
☐ Gout	☐ Blood Clots/DVT	☐ Epilepsy	☐ Lung Problems
☐ Tuberculosis	☐ Stroke	☐ Heart Failure	☐ Anemia
☐ Depression/Anxiety	☐ Liver Problems	☐ Circulatory Problems	☐ Asthma
☐ Cancer	☐ Heart Attack	☐ High Blood Pressure	☐ Ulcers
☐ Bleeding Disorder	☐ Irregular Heartbeat	☐ Varicose Veins	☐ Heart Disease
☐ C. Diff Positive	☐ MRSA Positive	☐ Hypothyroidism	☐ High Cholesterol
☐ Fibromyalgia	☐ Other__________	☐ **NONE**	☐ Dementia/Alzheimer's

Are you subject to (Please Check):

☐ Chest Pain	☐ Back Pain	☐ Foot/Leg Cramps	☐ Difficulty Breathing/Shortness of Breath
☐ Burning Pain	☐ Foot Pain at Rest	☐ Swelling Of Legs	☐ **NONE**

Do you have an immediate family history of (Please Check):

☐ Diabetes ☐ High Blood Pressure ☐ Arthritis ☐ Cancer ☐ Heart Disease ☐ **NONE**

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Patient Consent to Release Information

Name of Patient: ______________________________________ DOB: ____________________

(Please print)

I give permission to Tolboe Foot & Ankle, Inc. to contact me by using any of the following indicated methods for giving test results, discussing medical information, and/or confirming appointments.

Please mark all that apply:

- ☐ Mail
- ☐ Phone call — May we leave a message? ☐ Yes ☐ No
- ☐ Cellular Phone — May we leave a message? ☐ Yes ☐ No
- ☐ E-mail

Please list all authorized individuals to whom we may release health information.

Name(s) and Relationship:

____

____

____

____

Signature of Patient: _______________________________________ Date: _______________

Signature of Parent or Guardian: ______________________________ Date: ________________

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DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

In the event you are scheduled for surgery at either Stanislaus Surgical Hospital, LLC., or Valley Surgery Center, LLC., you need to know and acknowledge the following:

1. Our physicians, Christian R. Tolboe, DPM, FACFAS, CWS, David E. Paxton, DPM, AACFAS, MHA, and Dallen S. Pope, DPM, AACFAS. are owners in Stanislaus Surgical Hospital, LLC., and/or Valley Surgery Center, LLC.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Stanislaus Surgical Hospital, LLC., or Valley Surgery Center, LLC.

3. You will not be treated differently by our physicians if you choose to obtain health care services at a facility other than Stanislaus Surgical Hospital, LLC., or Valley Surgery Center, LLC.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of our office. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and herby understand that your physician has an ownership interest in Stanislaus Surgical Hospital, LLC., and/or Valley Surgery Center, LLC.

Patient Printed Name: ________________________________ DOB: ________________

Signature of Patient or Parent/Guardian: ________________________ Date: __________