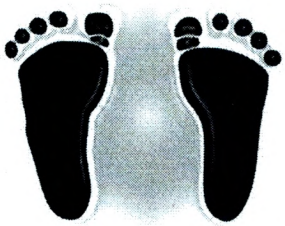
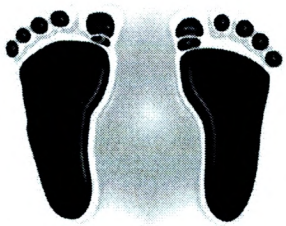


Ken G. Sakuda, D.P.M., LLC

Kuakini Medical Plaza
321 N. Kuakini Street, Suite 801
Honolulu, HI 96817
(808) 521-2002
FAX: (808) 521-0351



Patient Registration

Last_____ First _____ MI_____

BIRTHDATE_____/_____/_____ Age_____ Marital status_____ Male/Female

Address_____

City_____ State_____ Zip Code_____

Home(____) _____-_____Work(____)_____-_____Cell(____)_____-_____

*CONTACT FOR APPOINTMENT REMINDERS: (____)_____-_____Relationship_____

Emergency Contact _____Phone(___)_____-_____Relationship_____

Who may we thank for referring you to our office?_____

INSURANCE

Give cards to front office to make copy~ Enter ID# ONLY if you do **NOT** have your cards with you.

PRIMARY CARE PHYSICIAN:_____**PHONE**_____

Primary Insurance_____ I.D. #_____

Secondary Insurance_____I.D.#_____

SOCIAL HISTORY

Tobacco use: Yes☐ No☐ Former smoker☐
If yes, how long_____how often_____

☐ Alcohol Use
☐ Caffeine Use

List any physical activities:_____
_____

Occupation_____ ☐ Retired ☐ Disabled

By Signing below you acknowledge the above to be true

Print Name_____**Signature**_____

History & Medical Information

PODIATRIC HISTORY: ☐ **I am here for a DIABETIC FOOT CHECK** Shoe size_____

☐ Right

1. Explain your foot/ankle problem ☐ Left _____

☐ **Nail Fungus** ☐ **Ingrown Toenail** ☐ **Corns** ☐ **Wart** ☐ **Callus** ☐ **Bunion** ☐ **Thick nails** ☐ **Flat Feet**
☐ **Plantar Fasciitis** ☐ **Other(explain)** _____

2. When did pain/discomfort begin (date):_____

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other_____

3. What makes the pain/discomfort better: _____

4. Have you had a physical trauma? ☐ No ☐ Yes_____

5. Have you had an accident? ☐ No ☐ Yes_____

PAST MEDICAL HISTORY

☐ Anemia	☐ **GOUT**	☐ Thyroid Disorders	☐ Osteoarthritis
☐ Bleeding Disorders	☐ Heart Failure	☐ Lung/Respiratory Disorders	☐ Other Arthritis
☐ **Cancer**_____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ **DIABETES**	☐ High Cholesterol	☐ **Nerve Disorders**	☐ Stroke
☐ Epilepsy	☐ High Blood Pressure	☐ Prostate Disorders	☐ Kidney Disease
☐ Varicose veins	☐ HIV/AIDS	☐ Other: _____	☐ **Ulcers**

Surgical History: Have you had surgery? ☐ **No** ☐ **Yes**---if yes, describe:_____

Hospitalizations other than for surgeries: _____

FAMILY HISTORY

(List relationship of family member(s)who have had these problems)

☐ **Diabetes**_____	☐ Heart Disease_____	☐ Kidney Disease_____
☐ Hypertension_____	☐ Stroke_____	☐ Rheumatology_____
☐ Mental Illness_____	☐ Bleeding Disorders_____	☐ Cancer_____

☐ Other family History:_____

MEDICATIONS & ALLERGIES (if you have a list please give to front to make a copy)

List all medications/herbs/vitamins or **attach list**: _____

_____

_____

ALLERGIES: (Describe reaction) ☐ None ☐ Penicillin_____ ☐ Aspirin_____

☐ Narcotic Agent/Codeine_____ ☐ Anesthesia_____ ☐ Shellfish_____

☐ Nickel/Metal_____ ☐ Sulfa_____ ☐ Latex _____ ☐ Iodine_____

☐ Other_____ ☐ Anticoagulant Therapy_____ ☐ Demerol_____

Policies and Procedures Agreement

HIPAA PRIVACY POLICY

Please Initial ☐

I have read, received or been offered a copy of **Ken G. Sakuda, D.P.M.'s** Notice of Privacy Practices, (the "Notice"). I understand my information will be used for the purpose of treatment, payment, and healthcare operations as described within.

X-ray originals are owned by the doctor as they are a part of the medical record.

MEDICAL TREATMENT CONSENT

Please Initial ☐

I hereby authorize the doctor (and doctor's assistants or designated replacement) to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the care of the patient with my consent. I understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor or staff.

INSURANCE GUIDELINES

Please Initial ☐

I understand that my insurance policy is a contract between myself and my insurance carrier. **The medical office is a third party that bills the insurance as a courtesy to me.** Due to the large number of different insurance companies and their frequent changes, it is very difficult to keep track of each insurance plan's ever-changing, specifications and rules. While the medical staff will do their best to assist with insurance matters, **I understand that it is ultimately my responsibility to know what my insurance covers.** The doctor will assess and offer treatment based on the best medical options available, but if I have a question about coverage, **I have the responsibility to contact the insurance before accepting treatment.**

It is my responsibility to understand the terms of my contract with my insurance company in regard to copays, deductibles, and benefit amounts. Copays and deductibles will be collected at the time of service from the medical office. If my insurance company is delinquent on paying for my treatment, the medical office may request payment from me and will refund me once the insurance pays. If my insurance requires a referral it is my responsibility to obtain that before date of service.

Insurance Assignment and Release: **(INPUT INSURANCE COMPANY(S) HERE)**

I certify that I have insurance coverage with ↘_____and assign directly to **Dr. Ken G. Sakuda** all insurance benefits, if any, otherwise payable to me for services rendered.

MEDICARE/MEDIGAP AUTHORIZATION:

Please Initial ☐

I request that payment authorized Medicare benefits and if applicable, Medicare benefits, be made either to me or on my behalf to **Dr. Ken G. Sakuda** for any services furnished to me by that provider.

To extent permitted by law, I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

FINANCIAL AGREEMENT

Please Initial ☐

By signing below I agree to pay all amounts owed within 30 days of when such amounts are incurred. If I am unable to pay the full balance on my account, I will make payments each month toward the balance until it is paid off. The terms of this agreement apply to any present or future expenses incurred by me or by any individual for whom I have financial responsibility.

By signing below I agree to all the terms above.

X

_____

Signature, Guardian or Personal Representative Date

X

_____

Print Relationship to patient other than self