ROBERT K. BUCKENBERGER, D.P.M.

FOOT & ANKLE CENTER

559-439-8642 1642 E. Herndon Ave. Ste. 103
559-439-8341 Fresno, CA 93720

*** We are not contracted with HMO, Medi-Cal, or Covered California insurances. We accept Medicare, and most PPO insurances. ***

Dear Patient:

We are honored that you have chosen us for your podiatry needs.

Please fill out all forms completely, include a copy of your medical insurance card(s) front and back, and return all items in order to book an appointment.

The forms can be returned via:

1. **Fax:** 559-439-8341

2. **Bring/Mail in:** 1642 E. Herndon Ave. Ste. #103 Fresno, CA 93720
   (Our office will contact you within in 1 business day to schedule)

3. Non- HIPPA Compliant E-mail: Info@drbuckenberger.com
(Please note this email is not secure & our office is not liable for lost information)

On the date of your appointment please bring the following or we will have to reschedule:

- **Medical Insurance Cards-** if no cards are submitted, you can self-pay to keep appointment.
- **Photo ID-** is *required* at the time of check-in in order to protect you from identity theft.
- **Copayment-** Must be paid at time of service. We accept cash, check, or card, for your convenience.
- **For self-pay patients-** payment is due at the time service is rendered.

If you have any questions, please feel free to give us a call.

Thank you

ROBERT K. BUCKENBERGER, D.P.M.

_____

Has an Appointment

Day: _____ Date: _____

at: _____ A.M. _____ P.M.

If unable to keep appointment, kindly give 24 hour notice.

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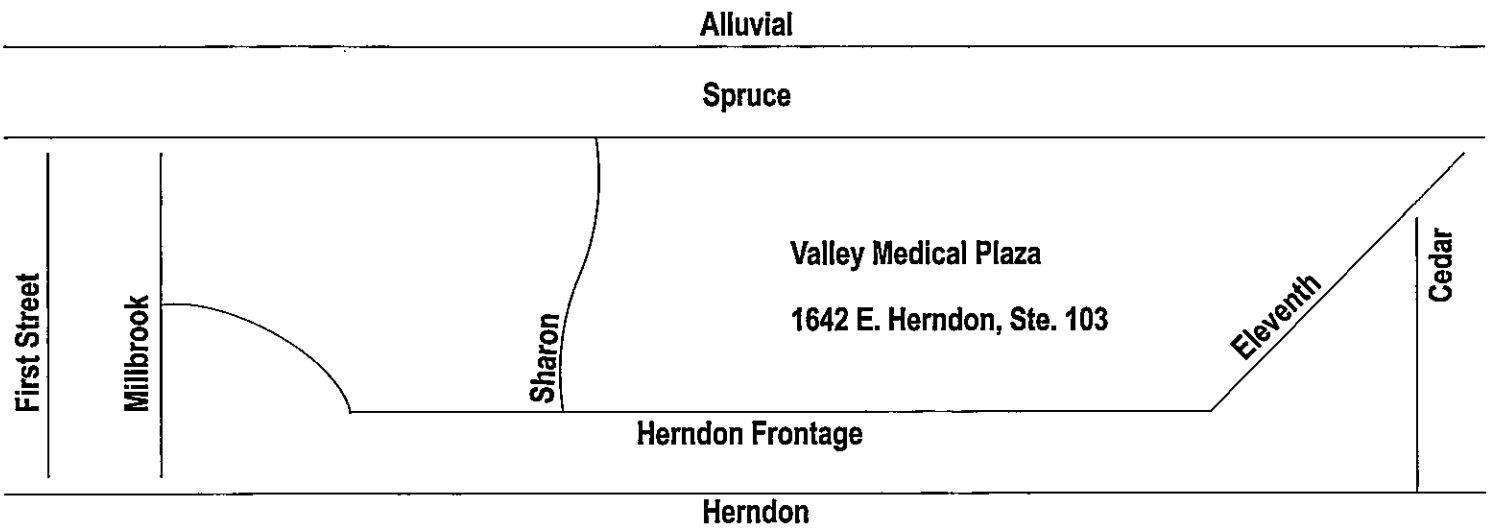

North on Cedar, first signal light (11th.) turn left.

5th driveway on the right side, turn right.

Office is located 2nd from the end building, suite # 103

Between John's Incredible Pizza and Sierra Pacific Orthopaedic Center

MAIN CROSS STREETS: CEDAR AND MILLBROOK

ON THE HERNDON FRONTAGE ROAD PARALLEL TO HERNDON AVENUE.

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FOOT & ANKLE CENTER

PATIENT INFORMATION FORM

PLEASE PRINT IN INK

Today's Date:_____

Name:_____ DOB:_____ Sex: ☐ M ☐ F SSN:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home #:_____ Work #:_____ Ext. ____ Cell #:_____

Email:_____

Spouse/Partners Name:_____ Phone: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Preferred Language _____

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to Specify

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Occupation:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Full Time Student ☐ Retired

Employer: _____ Address: _____

Primary Care Physician:_____ Phone #: _____

Referring Physician:_____ Phone #:_____

Emergency Contact Name: _____ Phone #:_____

Pharmacy Name:_____ Pharmacy Phone #: _____

Pharmacy Address:_____ City/State/Zip:_____

Primary Insurance:_____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name:_____ Relationship to insured: ☐ Spouse ☐ Child ☐ Other

Phone #: _____ Sex: ☐ Male ☐ Female DOB__/__/____

Address: _____ City/State/Zip _____

Policy ID:_____ Group ID: _____ Employer: _____

Secondary Insurance:_____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name:_____ Relationship to insured: ☐ Spouse ☐ Child ☐ Other

Phone #: _____ Sex: ☐ Male ☐ Female DOB__/__/____

Address: _____ City/State/Zip _____

Policy ID:_____ Group ID: _____ Employer: _____

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FOOT & ANKLE CENTER

HEALTH QUESTIONNAIRE

Name: _____ Todays Date: _____

Age: _____ Weight: _____ Height: _____ Shoe Size: _____

Reason for Visit? _____

Current Medical Problems (Including Those Being Treated by Medication):

- ☐ Anemia
- ☐ Ankle Pain
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Clots
- ☐ Chest Pain (Angina)
- ☐ Circulatory Problems
- ☐ Depression/Anxiety
- ☐ Diabetes (Type 1 or 2)
- ☐ Dizziness
- ☐ Emphysema-COPD
- ☐ Foot Pain
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of Vision, Cataracts
- ☐ Menopause
- ☐ Migraines
- ☐ Neuropathy
- ☐ Palpations
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Stents
- ☐ Strokes
- ☐ Tubal Ligation
- ☐ Urinary Problems

Other Medical Problems Not Listed: _____

Current Medication

☐ No Medications

Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____

Use back of Form if Additional Space Needed.

Allergies

☐ No Known Allergies

Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____

Use back of Form if Additional Space Needed.

Previous Surgeries: ☐ No Previous Surgeries

Family History (Please Indicate Family Members): ☐ No Known Family History

- ☐ Alzheimer's Mom / Dad Other: _____
- ☐ Arthritis Mom / Dad Other: _____
- ☐ Blood Clots Mom / Dad Other: _____
- ☐ Cancer Mom / Dad Other: _____
- ☐ Cataracts Mom / Dad Other: _____
- ☐ Circulatory Mom / Dad Other: _____
- ☐ Depression Mom / Dad Other: _____
- ☐ Diabetes Mom / Dad Other: _____
- ☐ Heart Disease Mom / Dad Other: _____
- ☐ High B. P. Mom / Dad Other: _____
- ☐ Strokes Mom / Dad Other: _____
- ☐ Other Mom / Dad Other: _____

Have you received the flu vaccine? ☐ yes ☐ no When? _____

Tobacco Use? ☐ Y ☐ N (Freq./Amount) _____ Alcohol Use? ☐ Y ☐ N (Freq./Amount) _____

Are You Pregnant? ☐ Y ☐ N

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FOOT & ANKLE CENTER

DISCLOSURE STATEMENT

Dear Patient,

Should Surgical intervention be necessary during the course of your treatment, you will have the choice of where the procedure will be performed. Dr. Buckenberger has a financial interest in the Fresno Surgical Hospital and Summit Surgical Center.

Please feel free to discuss your preferences in where you would like your surgery to be performed.

_____ _____

Robert K. Buckenberger, D.P.M. Patient's Initials

Acknowledgement of Privacy Practices

Notice of Privacy Practices: I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like a copy of Privacy Practices. ☐ Yes ☐ No.

_____

Patient Signature/Date

Assignment of Benefits and Consent for Treatment

I authorize any holder of Medical Information about me/family to release information to third party payors in order to determine benefits for services provided. I authorize payment by my third party payors directly to **DR. ROBERT BUCKENBERGER, DPM.** I permit a copy of this authorization to be used as an original. I have verified that the office of Dr. Robert Buckenberger is the facility I/my family may use for the insurance contract under which I/my family is covered. **I UNDERSTAND THAT IF THE PREVIOUS IS NOT TRUE, I AM RESPONSIBLE FOR PAYMENT OF CHARGES RELATED TO SERVICES, SUPPLIES, PRODUCTS, OR EQUIPMENT PROVIDED TO ME OR MY FAMILY.**

_____ _____

Signature Date

1642 E. Herndon, Ste. 103 • Fresno, CA 93720 • 559/**439-8642** • Fax: 559/439-8341

ROBERT K. BUCKENBERGER, D.P.M.
FOOT & ANKLE
CENTER

Missed Appointments- "No Show" Fees

This letter serves as notice that if you fail to give us a 24-hour notice of cancellation in the future, there will be a $30.00 cancellation fee billed to your account that is non-covered by your insurance. You will bear complete financial responsibility for this fee. Repeated missed appointments may result in dismissal from our practice.

Thanks for your understanding.

I have read the above, agree and understand.

Patient Signature:_____ Date:_____

FINACIAL POLICY

This financial policy states that an account that has a balance and has received 3 statements will require that it must be paid in full, or make payments arraignments until the account is current. Accounts with payment arrangements will require a credit card be held on the file that will be deducted on one of these dates each month, automatically: 1st, or the 15th. This service is offered at no charge. If account is not paid in full, or payment arrangements are not upheld, account will be turned over to a collection agency.

If payment arrangements are declined by the patient, full payment of balance is due upon receiving statement.

By signing, I acknowledge I have been made aware of the financial policy.

Printed Name:_____

Patient Signature: _____ Date:_____

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