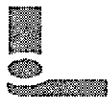


LEDESMA
FOOT + ANKLE

Patient Information

Patient Name:_____Date of Birth:_____

Mailing Address:_____

City_____State_____ZIP_____Primary Phone #_____

Home Phone #_____Cell or Work #_____

E-mail address:_____

Preferred method of communication from our office: ( ) e-mail ( ) home phone ( ) cell phone ( ) mail

Employer's Name:_____Occupation:_____

Employer's Address:_____

Is your insurance coverage through this employer? ( ) yes ( ) no. Is your insurance through your spouse? ( ) yes ( )no

Spouse's Name:_____Date of Birth:_____

Spouse's Employer Name:_____Phone #_____

Is this insurance through a parent or guardian? ( ) yes ( ) no. Name_____Birthdate_____

Policy holder's Name:_____Date of Birth:_____

Financial Information ( ) Self pay ( ) Insurance ( ) Medicare ( ) Worker's Comp ( ) Other

Primary Insurance:_____ID #_____

Group #_____Phone #_____

Secondary Insurance:_____ID#_____

Group #_____Phone #_____

Primary / Referring Physician's Name:_____Phone #_____

Address:_____

Would you like us to send medical records to this physician? ( ) yes ( ) no

Please let us know how you heard about us:

_____

Authorization for Release of Medical Information:

I hereby authorize Paul V. Ledesma, DPM to furnish my medical records consisting of, but not limited to, consultation notes, diagnostic test results, progress notes, operative reports and other medical information to the above stated physician. This release is in effect for one year from date noted.

_____Date_____

Signature of patient or patient's parent/legal guardian.

REASON FOR TODAY'S VISIT

Please describe your foot / ankle condition that you are seeing Dr. Ledesma for:_____

_____

Was this due to a work related injury? ( ) YES ( ) NO If yes, date of injury:_____

MEDICAL HISTORY

Have you had any surgeries or hospitalizations? ( ) YES ( ) NO If yes, please list dates and conditions:

_____

Have you had any past major illnesses? ( ) YES ( ) NO If yes, please list dates and conditions:

_____

Please tell us what medications you are currently taking: _____

_____

Height:_____ Weight:_____ Do you have high blood pressure? ( ) YES ( ) NO If yes, last known pressure: _____Approximate Date:_____

Are you diabetic? ( ) YES ( ) NO

If yes, is your diabetes controlled with ( ) diet ( ) insulin ( ) Medication (pills)

FAMILY HISTORY

Do you have any family members with these conditions:

( ) TB ( ) Cancer ( ) Diabetes ( ) High Blood Pressure ( ) Stroke ( ) Heart Condition

ALLERGIES

Environmental, Food, Latex, or Medication allergies. Please list:_____

_____

SOCIAL HISTORY

( ) Married ( ) Single ( ) Significant Other ( ) Divorced ( ) Widow

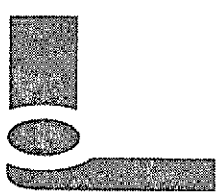
( ) Never Smoked ( ) Past Smoker, currently do not smoke ( ) Smoker ( ) Alcohol, how often_____

OTHER

Are there any other health conditions that were not covered by this questionnaire that Dr. Ledesma should know about? ( ) YES ( ) NO If yes, please explain: _____

_____

Patient Name: _____Date of birth:_____



Review of Symptoms (ROS)

(please check the appropriate spaces)

Gastro-Intestinal System

_Poor appetite
_Difficulty swallowing
_Vomiting food
_Constipation
_Hemorrhoids
_Weight Loss
_Stomach Trouble
_Ulcers
_Excessive Hunger
_Excessive thirst
_Gas
_Abdominal pain
_Black stool
_Liver Trouble
_Weight gain
_Appendicitis
_Difficulty chewing
_Nausea
_Indigestion
_Diarrhea
_Bloody Stool
_Gall bladder trouble
_Belching
_Other:_____

Genito-Urinary Systems

_Bladder trouble
_Painful urination
_Prostate trouble
_Kidney stones
_Excessive urination
_Discolored urine
_Difficult urination
_Kidney disease
_Scanty urination
_Frequent urination
_Blood in urine
_Other:_____

Nervous System

_Numbness
_Dizziness
_Muscle jerking
_Confusion
_Stroke
_Brain disease
_Loss of feeling
_Fainting
_Convulsions
_Depression
_Weakness
_Other:_____
_Paralysis
_Headaches
_Forgetfulness
_Spine disease
_Seizures

Vision/Eyes

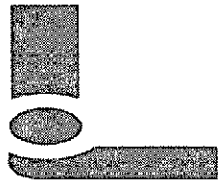
_Eye strain
_Eye disease
_Eye inflammation
_Eye injury
_Vision problem
_Impaired sight

Ear/ Nose/ Throat

_Ear pain
_Hearing loss
_Nose discharge
_Sore mouth
_Speech difficulty
_Ear noises
_Nose pain
_Breathing difficulty
_Sore throat
_Dental problems
_Ear discharge
_Nose bleeding
_Sore gums
_Hoarseness
_Other:_____

Cardio-Vascular

_Chest pain
_Heart attack
_Varicose veins
_Tiredness
_Feet swell
_Pain over heart
_High blood pressure
_Heart problems
_Weakness
_Other:_____
_Leg pain on walking
_Rapid heart rate
_Night sweats
_Hands swell



Continued ROS:

Respiratory

_Persistent Cough
_Lung Problems
_Coughing phlegm
_Wheezing
_Difficulty breathing
_Coughing blood
_Asthma
_Hay fever
_Bronchitis
_Emphysema
_Shortness of breath
_Other:_____

Integument

_Itching
_Skin rash
_Moles
_Deformed nails
_Hives
_Psoriasis
_Abrasions
_Discoloration
_Birth marks
_Others:_____
_Bruises
_Ulcerations
_Skin Cancers
_Eczema

Musculoskeletal

_Arthritis
_Joint disease
_Muscle Pain
_Sciatica
_Stiffness
_Bursitis
_Lumbago
_Other:_____
_Club foot
_Fractures
_Sprains

Allergies

_Penicillin
_Sulfa drugs
_Aspirin
_Any chemicals
_Morphine
_Antibiotics
_Codeine
_Other:_____
_Adhesive tape
_Any foods
_Other Drugs

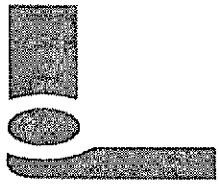
Hematology

_Anemia
_Take Aspirin
_Take Coumadin
_Jaundice
_Bleeding disorder
_Other:_____

_____
Patient Signature or Legal Guardian

_____
Legal Guardian (Print Name)

_____
Date



Financial Acknowledgement and Agreement - New Patient Form

Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not the insurance companies. Your insurance is a personal contract between you and your insurance company. If you would like us to file your claim for you, please provide your card to the receptionist. Without your card or proof of insurance, your claims cannot be filed. **Payment is due in full on the date of service,** unless other arrangements have been made or we have a contract stating otherwise with your insurance company. We accept cash, check, Visa, Master Card, and American Express.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered.

_____Date_____
Signature of Responsible Party

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Paul V. Ledesma, DPM. I also authorize the release of any medical or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete patient and insurance information on file.

_____Date_____
Signature of Responsible Party

HIPAA Acknowledgement

I have been presented with a copy of the Centers Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____Date_____
Signature of Patient

If not signed by the patient, please indicate relationship to patient. _____

Signature_____Date_____