Yuko Miyazaki, DPM
3000 Colby St, Suite 107 Berkeley, CA 94705
Phone: 510-647-3744 FAX: 510-764-2446

Patient Name _____Age _____**Date of Birth**_____
Home Address _____City _____State_____
ZiP _____**Home Phone**_____**Cell**_____
Work_____Email_____
Patient Employed By_____Occupation_____
Subscriber of Insurance: ( ) self ( ) spouse ( ) parent, if it is spouse or parent, give us
Name of Subscriber _____ Date of Birth_____
Address_____ City _____State__Zip____
Secondary insurance subscriber; ( ) self ( ) spouse ( ) parent, if it is spouse or parent,
Name of Subscriber _____Subscriber Date of Birth_____
How did you hear about us? Doctor, Google, Yelp, Friend, Insurance site, other_____
Primary Physician_____Dr's Phone _____
Last visit Primary Pysician_____
Previous Treatment of feet by a Doctor ( ) No ( ) Yes When _____Whom_____

Chief Foot Concerns_____
Weight _____**Height**_____ **Shoe Size**_____
Are you in General Good Health? ( ) Yes ( ) No If not,
Why?_____
Past illness and/or Operations?_____
Medication You Now Use_____
Name and Address of Pharmacy Patient Uses_____
If you have had or have any of the following, please check (x)

( ) Diabetes	( ) Low Back Pain	( ) Asthma	( ) Arthritis
( ) Blood Clot	( ) Liver Trouble	( ) Heart Trouble	( ) Tuberculosis
( ) Anemia	( ) High Blood Pressure	( ) Blood Disease	( ) Rheumatic Fever
( ) Stroke	( ) Bleeding Disorder	( ) Drug Reaction	( ) Gout
( ) Eye Trouble	( ) Other_____		

If you are allergic or sensitive to any of following, Please Check (X)
( ) Novocain ( )Penicillin ( )Sulfa ( )Adhesive Tape ( )Latex ( )Other_____

Do you smoke? NO, Yes: how much_____ Do you drink Alcohol? No, Yes how much_____

I hereby authorize Dr. Yuko Miyazaki permission to evaluate and treat my podiatric concerns. I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsive for non-covered services or supplies. I also authorize the release of medical information to the insurance company for purposes of billing for my treatment and to my pharmacy for prescription requests, if needed.

Date_____ Signature (Patient or Legal Guardian)_____

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NOTICE OF PRIVACY PRACTICE (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The law permits us to use or disclose your health information to those involved in your treatment. An example of this would be a specialist doctor who we involve in your care. We may also use or disclose your health information for payment of services. For example, we may send a report of medical progress to an insurance company. We may use or disclose your healthcare information for our normal office operations. For example, one of our staff will enter your information into our computer system. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may also use your information to contact you. We may want to contact you to confirm appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your healthcare information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your healthcare information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you indicate. You have the right to transfer copies of your health information to another practice, and we will assist with this transfer. You have the right to receive a copy of your health information with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment, we will not remove or alter earlier documents, but will add new information.

ACKNOWLEDGEMENT

I have received a copy of the Notice of Privacy Practices.

Patient/Guardian Signature Date Time