Yuko Miyazaki, DPM
2999 Regent Street, Suite 104, Berkeley, CA 94705
Phone: 510-647-3744 FAX: 510-764-2446

Patient Name ________________________________Age ______**Date of Birth**__________
Home Address ______________________________________City ____________________
State_____ ZIP____________**Occupation**______________________________________
Home Phone______________________ **Cell**______________ **Email**________________
Gender: Male____________**Female**______________**Other**_________________________

Subscriber of Insurance: ( ) self ( ) spouse ( ) parent, if it is spouse or parent, give us
Name of Subscriber ________________________________ Date of Birth________________
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 Physician__________________________
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	( ) Thyroid
( ) 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 responsible 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)_____________________________________

Dr. Yuko Miyazaki D.P.M. Inc.
2999 Regent Street, Suite 401, Berkeley, CA 94705
Tel: 510-647-3744 Fax: 510-764-2446
Email: Dr.yukom@gmail.com Website: JustFootAnkle.com

Financial Policy

Welcome and thank you for choosing our Medical practice for your healthcare needs. In our effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read our **Financial Policy**, fill out the demographic and health history forms for your medical file.

If at any time you have a question regarding our office policies do not hesitate to contact us. Your clear understanding of our **Financial Policy** is important to our professional relationship. We are a Medicare provider and also a provider for most PPO and some HMO plans. It is your responsibility to make sure we are on your insurance plan. If your insurance requires a referral or prior authorization, it is your responsibility to make sure that it is in place prior to your appointment. We will be glad to assist you if you need help.

All co-payments are due at the time of your visit. **If you have an unmet deductible we pre-collect 60% of the charges** incurred that your insurance will apply towards your deductible. If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed to you and due at that time.

Name__________________________ **Signature**_____________________________
Date____________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient (please print):____
Signature: Patient______________________________________ Date _________________

THERE IS A 24 HOUR CANCELLATION REQUIREMENT. YOU WILL BE CHARGED $40 FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS.

SIGNATURE____________________________________