CONCIERGE
PODIATRY & SPA NEWPORT BEACH

Patient's Name	Name to be called	Birthdate	Age	Marital Status
				◉ S ○ M ○ D ○ W

Address	Mobile Number

Responsible Party (if patient is a Minor)	Relationship	Email Address:	Home Phone Number

Spouse's Name	Spouse's Phone Number	Spouse's Birthdate	Best Contact Time
			☐ AM ☐ PM ☐ Evening ☐ Other

Spouse's Address (if Different)	How did you hear about our office?
	☐ Magazine ☐ Internet ☐ Social Media ☐Our Sign ☐Other ☐ Yelp ☐ Friend ☐ Patient ☐ Physician Who should we thank?

Family Doctor	Doctor's Address	Doctor's Phone Number

Emergency Contact	Relationship	Contact's Address:	Contact's Phone Number

INSURANCE INFORMATION

Dr. Roth is an out of network provider. His patients pay in full at the time of service. As a courtesy, our office will submit your PPO claim to your insurance company on your behalf and instruct your insurance company to send the benefits directly to you. **If you would like us to submit claims to your PPO, please bring a copy of your insurance card on your first visit.**

I will pay for services by: ☐ Cash ☐ Check ☐ Credit Card

PLEASE BE SPECIFIC IN ANSWERING THE FOLLOWING QUESTIONS:

Describe your Foot/Ankle problem	Duration of problem

How did it occur? (if by accident)	Have you ever had Foot/Ankle X-Rays? ☐ Yes When? _____

Describe past treatment(s), if any	Surgery/Hospitalizations, if any

Do You Have a History of		Are You Allergic to
☐ Arthritis	☐ Asthma	Adhesives
☐ High Blood Pressure	☐ Bleeding Complications	Penicillin
☐ Ulcers	☐ Cancer	Codeine
☐ Diabetes	☐ Liver Problems	Iodine
☐ Heart Problems	☐ Stomach Problems	Aspirin
☐ Lung Problems	☐ Do You Drink?	Local Anesthetic
☐ Kidney Problems	☐ Do You Smoke?	Other
	None of the Above	**None of the above**

List of current medications and dosages ☐ **None**

_____ _____ _____

_____ _____ _____

I hereby give my permission to Dr. Ivar E. Roth and/or his associates to administer treatment and to perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my foot/ankle condition(s). I understand that I am financially responsible to Dr. Roth for professional services when rendered. I also give my permission to contact my references or employment to obtain additional information if necessary. Lastly, I authorize Dr. Roth to release information acquired during my examination or treatment to the appropriate entities as it relates to my services.

Signature of Responsible Party _____ Date _____