BOBBY YEE, D.P.M
880 CASS ST., SUITE 201, MONTEREY CA, 93940 P: 831-646-8242 FAX: 831-646-8373
601 E. ROMIE LN., SUITE 7, SALINAS CA, 93901 P: 831-754-6830 FAX: 831-754-0646

PATIENT INFORMATION

REGISTRATION FORM (PLEASE PRINT CLEARLY)

Primary Language: English ___ Spanish ___ Other ___			
Patient's Last Name	First		Middle
Home Address	City	State	Zip Code
Mailing Address (if different from above)	City	State	Zip Code
Home Phone#	Work Phone#	Occupation:	
Cell Phone#	e-mail address:		

Date of Birth	Age	Social Security#	Marital Status () Single () Married () Widow () Divorce	Gender () M () F

(If Minor) Person Responsible For Bills	Relation to Patient	Social Security#	Date of Birth
Mailing Address	City	State	Zip Code

INSURANCE INFORMATION (DR. YEE'S OFFICE DOES NOT TAKE MEDI-CAL)
It is my responsibility to furnish Dr. Yee any Medical Benefit Card/s that I have primary and secondary. If I am unable to provide the necessary information within 12 hours after my appointment it will then be my responsibility to pay for services in full and submit for reimbursement to my insurance company on my own.

Primary Insurance Name:		Subscriber's Name-Name of whom Ins. is under	
Subscriber's S.S#	Subscriber's ID	Co-Payment	

Patient's Relationship to Subscriber () Self () Spouse () Child () Other Subscriber's Birth Date ____

Secondary Insurance Name		Subscriber's Name- Name of whom Ins. is under	
Subscriber's S.S#	Subscriber's ID#	Co-Payment	

Patient's Relationship to Subscriber () Self () Spouse () Child () Other Subscriber's Birth Date ____
IS THIS A WORKER'S COMP INJURY? YES () NO () DATE OF INJURY / /

EMERGENCY CONTACT INFORMATION
NAME_____**RELATIONSHIP**_____**PHONE#**_____

WHO REFERRED YOU TO OUR PRACTICE?
() Doctor _____ () Friend _____
() Hospital _____ () Other _____

Race () American Indian () Alaska Native () Asian () Black or African American () Native Hawaiian or other Pacific Islander () white () Decline to Specify

Ethnicity () Not Hispanic or Latino () Hispanic or Latino () Decline to Specify

I authorize the processing of my insurance and payment to Dr. Bobby Yee. I do agree and acknowledge I am responsible for any and all professional services rendered by Dr. Bobby Yee. I will be charged for cancelled or broken appointment without 24 hours advance notice. I have also received the notice of privacy practices and I have been provided an opportunity to review it.

Patient Signature **Date**

MEDICAL HISTORY

Patient's Last Name **First** **Birth Date**

What foot/ankle problem brings you to the doctor?	How Long?	Months	Years
How have you been treated for the current problem? Yes No			

() Surgery	() Orthotics	() Oral Medication	() Cortisone shots () Other

Do you have an X-Rays, MRI, or CT Scan for the current problem () Yes () No

Shoe Size	Height	Weight

MEDICAL HISTORY

Arthritis/Rheumatism	Yes	No	High Blood Pressure	Yes	No
Artificial Joints (hips, knee, etc.)	Yes	No	High Cholesterol	Yes	No
Asthma	Yes	No	H.I.V. Positive	Yes	No
Cancer	Yes	No	Kidney Trouble	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Diabetic Foot Ulcers	Yes	No	Neurological Disorder	Yes	No
Fibromyalgia	Yes	No	Psychiatric/Psychological Care	Yes	No
Bleeding disorders	Yes	No	Stomach Ulcer/Reflux/Heartburn	Yes	No
Heart Disease or Attack	Yes	No	Glasses or Contact Lens	Yes	No
Heart Murmur	Yes	No	Other:		
Hepatitis (indicate) () A () B () C	Yes	No	Other:		
Do you drink?	Yes	No	**If Yes, Drinks Per Week**		
Do you Smoke?	Yes	No	**If Yes, Pack(s)/day**		
Are you pregnant? () Yes () No					

INDICATE ANY SURGICAL PROCEDURES YOU HAVE HAD IN THE PAST

PAST PODIATRIC HISTORY	**YES**	**NO**	**FAMILY HISTORY**	**YES**	**NO**	**RELATIONSHIP**
Athlete's Foot			Alcoholism			
Ankle Pain			Arthritis			
Bunion			Asthma			
Corns/Calluses			Breast Cancer/			
Cramps in Legs			Cancer			
Flat Feet			Diabetes			
Heel Pain			Heart Disease			
Ingrown Toenail			Hypertension			
Neuroma or Nerve Pain			High Cholesterol			
Plantar Warts			Kidney Disease			
Swelling			Smoking			
			Stroke			
Other:			Other:			

Current medication you are taking: Prescription and over the counter.

NAME OF PREFERRED PHARMACY: _____ LOCATION: _____

Patient's Last Name	**First**	**Birth Date / /**
MEDICATION	DOSE/MG /TIMES A DAY	START DATE (ESTIMATE)

ALLERGIES (LIST KNOWN ALLERGIES TO DRUGS/MEDICATIONS & REACTIONS TO THEM)
() Penicillin () Sulfa () local Anesthetic () Iodine on Skin () Aspirin () Codeine () Tape () Anti-inflammatory Medication () None () other_____
If any allergies, what type of reaction () Difficulty breathing () Rash () Stomach upset

FAMILY PHYSICIAN INFORMATION			
Medical Doctor's Name		Medical Doctor's Phone Number	
Street Address	City	State	Zip Code
Date of last Physical Exam / /	Date of last blood test / /		
MEDICAL HISTORY AFFIRMATION I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Dr. Bobby Yee has my permission to ask the respective health care provider or agency, who may release such information to Dr. Bobby Yee. I will notify the doctor of any changes in my health or medication			
Patient Signature		Date	/ /