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PATIENT INFORMATION

PATIENT (LAST NAME, FIRST NAME):_____

Name you prefer to be called (Mr. Smith, Mrs. Jones, Bob, etc):_____

Date of Birth:_____ Sex: ☐ Male ☐ Female ☐ Decline to answer

Patient's Address:_____ Apt # _____

City, State, Zip:_____ E-mail:_____

Primary Phone Number:_____ Cell Phone Number:_____

Social Security #:_____ Driver's License #:_____

Occupation:_____

How did you hear about our practice/ whom may we thank for referring you?

☐ Google Search ☐Google Maps ☐ Yelp ☐ Instagram ☐ Facebook ☐ YouTube ☐ Existing Pt

☐ Referring Doctor:_____ ☐ Other: _____

SPOUSE/ PARENT/ GUARDIAN INFORMATION

Name (Last, First):_____ Date of Birth:_____

Phone Number:_____

EMERGENCY CONTACT (If Different from Guarantor)

Name:_____ Relationship:_____

Phone Number:_____

PHARMACY INFORMATION

Pharmacy Name:_____ Phone #:_____

Address:_____

City, State, Zip:_____

I hereby authorize Dr. Charles Baik and his associates to examine, photograph, administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle problem.

I assign the right to payment for all medical benefits directly to Dr. Charles Baik in consideration for medical services and supplies provided pursuant to my health insurance plan.

I give consent to Dr. Baik to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to Dr. Baik to send medical information, as necessary to my insurance plan. I agree that a photocopy of this form may be used in lieu of the original.

I certify the patient information form is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature:_____ Date:_____

If Legal Representative, Relationship to Patient:_____

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PATIENT HEALTH HISTORY

Height:_____ Weight:_____

Briefly describe your foot/ankle problem:_____

_____

If female, are you pregnant? ☐ Yes ☐ No If so, How many months? LMP:_____

Family Doctor: _____ Phone # _____

Review of Systems (Please check if any of the following currently exist):

Constitutional:	☐ Chills	☐ Fever	☐ Weight loss
Head:	☐ Dizziness	☐ Headaches	☐ Fainting
Musculoskeletal:	☐ Arthritis	☐ Gout	☐ Muscle cramps

Allergies: ☐ None, ☐ Penicillins, ☐ Sulfa, ☐ Local Anesthetics, ☐Codeine, ☐Aspirin, ☐ Adhesive Tapes, ☐ Iodine, ☐ Other:_____

Medications: Are you taking any (Prescription, Birth Control Pills, or Over-the-Counter)? If yes, what are they? (Please include dosage and strength if known) _____

_____

Do you give us permission to access your medication history electronically?

☐ Yes ☐ No

Medical History: ***Please check if any of the following problems exist or have occurred in the past***

☐ Diabetes — Type I	☐ Osteoarthritis	☐ Stomach Ulcers
☐ Diabetes — Type II	☐ Rheumatoid Arthritis	☐ Foot Ulcers
☐ Rheumatic Fever	☐ High Blood Pressure	☐ Tuberculosis
☐ Stroke	☐ Gout	☐ Collagen/Vasc. Disease
☐ Kidney Disease	☐ Heart Trouble	☐ Epilepsy
☐ Liver Disease	☐ Heart Murmur	☐ Ankle Sprains
☐ Asthma	☐ Varicose Veins	☐ Infections
☐ Hepatitis	☐ Sickle Cell Anemia	☐ Cancer_____ Remission?_____
☐ AIDS or HIV exposure	☐ Bleeding problems	☐ Low Back Pain
☐ Lymphedema	☐ Anemia	☐ Leg Cramps
☐ Thyroid Disease	☐ Phlebitis	☐ Numbness to Feet/Legs
		☐ Other:

Family History:

Father: Positive history for:_____ ☐ ALIVE ☐ DECEASED

Mother: Positive history for:_____ ☐ ALIVE ☐ DECEASED

Social History:

☐ Current Smoker ☐ Former Smoker?

If YES to either, how many Cigarettes per day?_____ For how long?____ YRS/MO

☐ Alcohol? If so, how many drinks per day?_____

Surgical History:

_____

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FINANCIAL POLICY

Our goal is to maintain a good physician–patient relationship through clear communication. Please review this policy carefully and initial each section.

Financial Responsibility Initials: _____

- You are responsible for all co-payments, deductibles, coinsurance, and non-covered services as determined by your insurance plan.
- Co-payments are due at the time of service.
- Self-pay patients must pay in full at the time of the visit.
- Balances are due within 10 business days after receiving your bill.
- Accounts unpaid after 90 days without arrangements may be sent to collections.
- We accept cash, checks, Visa, and MasterCard.
- A $25 fee applies to returned checks.
- If you have trouble paying, please contact us promptly—payment arrangements may be available.

Insurance Initials: _____

- We bill your insurance as a courtesy; however, payment is ultimately your responsibility if your insurer does not pay due to inaccurate/untimely information or claim denial.

No-Show & Late Cancellation Policy Initials: _____

- If you cannot keep this or any other appointment, please advise us as early as possible.
- If you do not call to cancel or re-schedule your appointment within 24 hours of the appointment time, you may be charged $50.00.
- We reserve the right not to reschedule patients who have multiple cancellations.

Acknowledgment

I have read, understand, and agree to comply with this policy. I accept responsibility for any balance due.

Patient Name: _____ Date: _____

Responsible Party Signature: _____

****"A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."**

CHARLES BAIK, DPM — RENEW PODIATRY
705 W. La Veta Ave. Ste. 109 · Orange, CA 92868 · (714) 832-7212

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights	Your Choices	Our Uses and Disclosures
You have the right to:	*You have choices about how we share information as we:*	*We may use and share your information as we:*
• Get a copy of your medical record • Correct your medical record • Request confidential communication • Ask us to limit what we share • Get a list of those we've shared your information with • Get a copy of this notice • Choose someone to act for you • File a complaint if you believe your privacy rights were violated	• Tell family and friends about your condition • Share information in a disaster relief situation *See page 2 for details on each choice.*	• Treat you • Run our practice • Bill for your services • Help with public health and safety issues • Comply with the law • Respond to lawsuits and legal actions

For more information see: www.hhs.gov/hipaa/for-professionals/privacy/index.html

Your Rights, In Detail

Get an electronic or paper copy of your medical record

- You can ask to see or get a copy of your medical record and other health information we have about you. We will provide a copy within 30 days, and may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct information you think is incorrect or incomplete. We may say no, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, cell phone only) or send mail to a different address. We will accommodate all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to share certain health information for treatment, payment, or operations. We are not required to agree, and may say no if it could affect your care.
- If you pay out-of-pocket in full for a service, you can ask us not to share information about that service with your health insurer. We will agree unless the law requires otherwise.

Get a list of those we've shared your information with

- You can ask for an accounting of disclosures made in the last six years (excluding treatment, payment, and operations). The first list each year is free.

Get a copy of this notice

- You can ask for a paper copy of this notice at any time, even if you agreed to receive it electronically.

Choose someone to act for you

- If someone has your medical power of attorney or is your legal guardian, they can exercise your rights on your behalf once we verify their authority.

File a complaint

- You may complain to us using the contact information above, or to the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue SW, Washington, D.C. 20201, 1-877-696-6775, www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint.

Your Choices, In Detail

- Share information with family, close friends, or others involved in your care or payment for care — unless you tell us not to.
- Share information in a disaster relief situation.

We do not use your information for marketing or fundraising, and we do not sell your health information. Any such use would require your written authorization.

If you are unable to tell us your preference (for example, in an emergency), we may share information if we believe it is in your best interest.

Our Uses and Disclosures, In Detail

Treat you

- We use and share your health information with other professionals involved in your care.

Run our practice

- We use your information to manage your treatment, improve care, and contact you when necessary.

Bill for your services

- We share your information with your health plan so it will pay for the services we provide.

Help with public health and safety issues

- As permitted or required by law — for example, to prevent disease, report suspected abuse or neglect, or reduce a serious threat to health or safety.

Comply with the law

- We will share information about you if state or federal law requires it, including with HHS to confirm compliance with federal privacy law.

Respond to lawsuits and legal actions

- We can share information in response to a court or administrative order, or a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised your information.
- We must follow the duties and privacy practices described in this notice.
- We will not use or share your information other than as described here unless you tell us in writing that we can. You may withdraw that permission in writing at any time.

Changes to This Notice

We may change the terms of this notice, and the changes will apply to all information we have about you. The revised notice will be available at our office and on our website.

Effective Date and Contact

Effective Date: 9/2/2026

Privacy Contact: (714) 832-7212. info@renewpodiatry.com

Acknowledgment of Receipt

I acknowledge that I received (or had the opportunity to review) this Notice of Privacy Practices.

Patient Name (print): _____

Signature: _____ Date: _____

Parent/Authorized Representative (if applicable): _____