



# Foot & Ankle Doctors, Inc.

240 S. La Cienega Blvd. Suite 300  
Beverly Hills, CA 90211  
Telephone: (310) 652-3668 Fax: (310) 652-3669

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## Patient Information (Please Print)

Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referred By: Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Physician: Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Last Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Pharmacy Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

## EMPLOYMENT INFORMATION

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

In Case of Emergency, Please Call: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

## INSURANCE INFORMATION

Patient's Relationship to Insured: \_\_\_ Self \_\_\_ Husband \_\_\_ Wife \_\_\_ Child \_\_\_ Other: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address (if different): \_\_\_\_\_

Insurance Company(ies) Name: \_\_\_\_\_

Group Number(s): \_\_\_\_\_ Policy Number(s): \_\_\_\_\_

## COMPREHENSIVE MEDICAL HISTORY

### Allergies:

- Penicillin
  - Sulfa drugs
  - Aspirin
  - Codeine
  - Antibiotics
  - Iodine/Shellfish
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- Latex
- Other Allergies: \_\_\_\_\_

### Current Medication List:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Do you have or have you ever been treated for:

- |                                      |  |  |  |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Stroke      | <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Substance Abuse   |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Vascular Disease  | <input type="checkbox"/> A Heart Condition             | <input type="checkbox"/> Difficulty to stop bleeding   |
| <input type="checkbox"/> Anemia      | <input type="checkbox"/> Poor Circulation  | <input type="checkbox"/> Eyes: Glaucoma/Manicular Deg. | <input type="checkbox"/> Polio   |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Keloid/Thick Scar             | <input type="checkbox"/> Breathing Problems  |
| <input type="checkbox"/> Gout        | <input type="checkbox"/> Osteoporosis      | <input type="checkbox"/> Alzheimer's                   | <input type="checkbox"/> Phlebitis   |
| <input type="checkbox"/> Sciatica    | <input type="checkbox"/> Lyme's Disease    | <input type="checkbox"/> Rheumatic Fever               | <input type="checkbox"/> Any implants in your body including, orthopedic, Cardiac, Cosmetic, et. |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Hearing/Ear Disorder          | <input type="checkbox"/> <b>NONE of these</b>  |
| <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> Nerve Disorder    | <input type="checkbox"/> Psychiatric Disorder          |  |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Lung Disease      | <input type="checkbox"/> Tuberculosis                  |  |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Liver Disease     | <input type="checkbox"/> Thyroid Problem               |  |
| <input type="checkbox"/> Dark Urine  | <input type="checkbox"/> Chronic Lt. Stool | <input type="checkbox"/> Unexplained Weight Loss       |  |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Stomach Ulcer     | <input type="checkbox"/> HIV/AIDS                      |  |
- Other(s): \_\_\_\_\_

### List relationship to you of family members who have had:

- |  |  |
|--|--|
| <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Foot Problems _____       |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Heart Attack _____        |
| <input type="checkbox"/> Stroke _____    | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cancer _____    | <input type="checkbox"/> Birth Defects _____       |
| <input type="checkbox"/> Other _____     |  |

**COMPREHENSIVE MEDICAL HISTORY (continued)**

**Do you smoke now?**     No     Yes    Packs/day \_\_\_\_\_    Years \_\_\_\_\_

**Did you ever smoke?**     No     Yes    Packs/day \_\_\_\_\_    Years \_\_\_\_\_

**If you quit, when did you do so?** \_\_\_\_\_

**Alcoholic beverages?** (*Circle one*):    None    Rarely    Moderately    Daily    Quit

**Recreational Drugs?** (*Circle one*):    None    Rarely    Moderately    Daily    Quit

**Primary Language:** \_\_\_\_\_

**Race:**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White

**Ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino

**Have you had/been treated for:**

- |  |   |
|--|---|
| <input type="checkbox"/> Rash                    | <input type="checkbox"/> Athlete's Foot       |
| <input type="checkbox"/> Corns/Calluses          | <input type="checkbox"/> Ingrown nails        |
| <input type="checkbox"/> Leg or Foot Ulcers      | <input type="checkbox"/> Foot Numbness        |
| <input type="checkbox"/> Broken foot bone(s)     | <input type="checkbox"/> Ankle sprain         |
| <input type="checkbox"/> Hammer/Mallet toes      | <input type="checkbox"/> Flat feet            |
| <input type="checkbox"/> Cramps in legs/feet     | <input type="checkbox"/> High arch feet       |
| <input type="checkbox"/> Lower back pain         | <input type="checkbox"/> Heel pain            |
| <input type="checkbox"/> Gait (Walking) problems | <input type="checkbox"/> Toe walking          |
| <input type="checkbox"/> Childhood foot problems | <input type="checkbox"/> <b>NONE of these</b> |

**Previous Injuries:**

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**Previous Surgeries:**

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**Previous Hospitalizations:**

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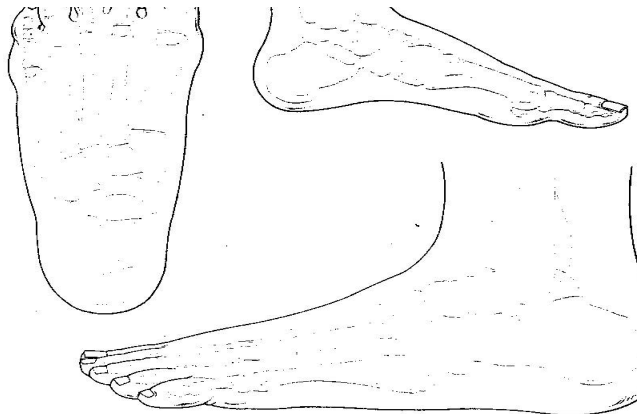
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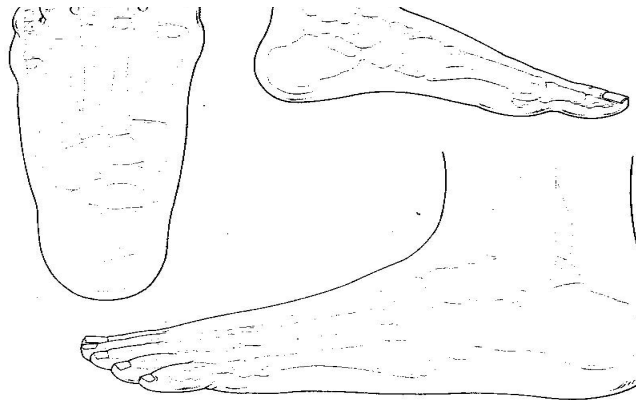
## PATIENT'S CURRENT CHIEF COMPLAINTS

Describe 1 or 2 main problems in greater detail below and mark on the diagrams the areas where you have each problem using numbers 1 and 2 to identify them.

### LEFT FOOT



### RIGHT FOOT



**1.)** Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain below

My first problem is:

On Left foot    On Right foot    On Both feet

It causes me difficulty:

walking,    wearing shoes, and/or it ...

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is problem work related?    Y    N

Date of injury:   \_\_\_ / \_\_\_ / \_\_\_\_

Date of report to employer:   \_\_\_ / \_\_\_ / \_\_\_\_

**1.)** Please mark the location of your second problem or pain on the diagrams above with a number 2. Describe your problem below and its cause if you know. Please describe associated pain below

My first problem is:

On Left foot    On Right foot    On Both feet

It causes me difficulty:

walking,    wearing shoes, and/or it ...

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is problem work related?    Y    N

Date of injury:   \_\_\_ / \_\_\_ / \_\_\_\_

Date of report to employer:   \_\_\_ / \_\_\_ / \_\_\_\_

**2.) PAIN:** Please indicate the severity of your pain or discomfort:

None    Light    Moderate    Strong    Severe

**My Pain/Discomfort is:**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Shooting Pain  | <input type="checkbox"/> Aching Pain |
| <input type="checkbox"/> Throbbing Pain | <input type="checkbox"/> Tenderness  |
| <input type="checkbox"/> Sharp Pain     | <input type="checkbox"/> Dull Pain   |
| <input type="checkbox"/> Burning Pain   | <input type="checkbox"/> Tingling    |
| <input type="checkbox"/> Itching        | <input type="checkbox"/> Numbness    |

**How long ago did the problem (pain) start?**

\_\_\_    days,    weeks,    months,    years ago

**The pain from my problem occurs:**

- while walking   and/or    while not walking
- and/or: \_\_\_\_\_

**Previous medical treatment(s) or home remedies:**

\_\_\_\_\_

**2.) PAIN:** Please indicate the severity of your pain or discomfort:

None    Light    Moderate    Strong    Severe

**My Pain/Discomfort is:**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Shooting Pain  | <input type="checkbox"/> Aching Pain |
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| <input type="checkbox"/> Sharp Pain     | <input type="checkbox"/> Dull Pain   |
| <input type="checkbox"/> Burning Pain   | <input type="checkbox"/> Tingling    |
| <input type="checkbox"/> Itching        | <input type="checkbox"/> Numbness    |

**How long ago did the problem (pain) start?**

\_\_\_    days,    weeks,    months,    years ago

**The pain from my problem occurs:**

- while walking   and/or    while not walking
- and/or: \_\_\_\_\_

**Previous medical treatment(s) or home remedies:**

\_\_\_\_\_

# New HIPAA Privacy Regulations

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of Foot & Ankle Doctors, Inc. will not reveal to any person personal information about you or about a family member (i.e. name, address, Social Security Number, as well as other health information) without permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation or fund raising.

It is however understood, that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing, paper and wire, (includes fax transmissions) Insurance company follow up or interaction with billing services relating to patient care
- Pursue collection of unpaid bills
- Hospital workers, nurses, aids and medical records department
- Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses, or technicians
- Personal Religious designate
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

*I authorize the release of this necessary information.*

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Authorization/Consent for Messages and Treatment

## **Contact Preferences:**

Phone Number(s): \_\_\_\_\_

Okay to leave message with:  patient only  patient and/or spouse  anyone answering phone

Patient's email address: \_\_\_\_\_

\_\_\_ **Yes, I authorize medical information to be left for the above contact preferences.**

\_\_\_ **NO, I do not authorize any medical information to be released.**

Patient's/Guardian's Signature \_\_\_\_\_

As patient or legal guardian, I hereby give permission to Foot & Ankle Doctors, Inc. to administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition. I understand that any unpaid balance, not paid by my insurance company, becomes my responsibility and is due in full within 30 days of receipt of statement.

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE TO CONSUMERS

**Medical doctors are licensed and regulated by the Medical Board of California  
(800) 633-2322**

[www.mbc.ca.gov](http://www.mbc.ca.gov)

By signing below, I understand the physicians, David Dardashti, DPM and Farshid Nejad, DPM, are licensed and regulated by the board.

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_