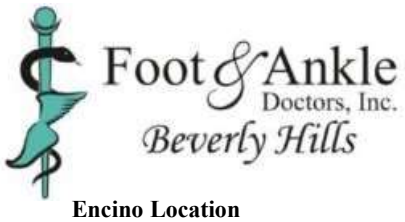


Beverly Hills Location
9100 Wilshire Blvd Suite # 280E
Beverly Hills, CA 90212
P: (310) 652-3668
F: (310) 652-3669

Encino Location
16311 Ventura Blvd Suite 650
Encino, CA 91436
P: (818) 981-1808
F: (818) 981-1816

Marina Del Rey
8540 S. Sepulveda #116
Los Angeles, CA 90045
P: (310) 652-3668
F: (310) 652-3669

Los Alamitos
10961 Cherry St
Los Alamitos, CA 90720
P: (562) 799-0992
F: (562) 799-0298

Patient Information (Please Print)

Last Name: _____ MI: _____ First Name: _____

Social Security #: _____-_____-_____ Date of Birth: ____ / ____ / _____ Age: _____ Sex: M F

Home Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____-_____Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Referred By: Name: _____ Phone: (____) ____-_____

Primary Physician: Name: _____ Phone: (____) ____-_____ Last Visit: ___/___/___

Pharmacy Name:_____ **Pharmacy Phone: (____) _____-_____**

Pharmacy Address:_____ **Home Health Name :_____**

Home Health Phone: (____) ____-_____ **Address:_____**

Primary Language: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Shoe Size: _____ Weight:_____

A1C: _____%

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
□ Other_____

EMERGENCY CONTACT INFORMATION

In Case of Emergency, Please Call: _____ Phone: (____) _____-_____

Relationship to the Patient: _____

EMPLOYMENT INFORMATION

Employer Name:_____ Occupation:_____

Employer Address:_____ City:_____ State_____ Zip:_____

COMPREHENSIVE MEDICAL HISTORY

Allergies:

□ Antibiotics
□ Aspirin
□ Codeine
□ Iodine/Shellfish
□ Latex
□ Penicillin
□ Sulfa Drugs
□ Other Allergies:
□ **NONE**

Current Medication List:

_____
_____
_____
_____
_____
_____
_____
_____

Please indicate if <u>Mother or Father</u> has had any of the following:

□ Arthritis: MOM or DAD
□ Birth Defects: MOM or DAD
□ Cancer: MOM or DAD
□ Diabetes: MOM or DAD
□ Foot Problems: MOM or DAD
□ Heart Attack: MOM or DAD
□ High Blood Pressure: MOM or DAD
□ Stroke: MOM or DAD

Do you have or have you ever been treated for:

□ Anemia
□ Ankle sprain
□ Asthma
□ Alzheimer's
□ Arthritis
□ Arch pain
□ Athlete's Foot
□ Breathing Problems
□ Broken foot bone(s)
□ Broken Ankle
□ Bunions
□ Cramps in legs/feet
□ Corns/Calluses
□ Cancer
□ Childhood foot problems
□ Chronic Lt. Stool
□ Diabetes : A1C_____
□ Dark Urine
□ Difficulty to stop bleeding
□ Epilepsy
□ Eyes: Glaucoma/Manicular Deg
□ Flat feet
□ Foot Numbness
□ Fungal Nails
□ Gout
□ Gait (Walking) problems
□ Heart Condition
□ Hepatitis
□ Heart Attack
□ Headaches
□ Hearing/Ear Disorder
□ High Blood Pressure
□ HIV/AIDS
□ Hammer/Mallet toes
□ Heel pain
□ High arch feet
□ In-toeing
□ Ingrown nails
□ Keloid/Thick Scar
□ Kidney Disease
□ Knee pain
□ Leg or Foot Ulcers
□ Liver Disease
□ Lyme's Disease
□ Lower back pain
□ Lung Disease
□ Neuroma
□ Nerve Disorder
□ Osteoporosis
□ Polio
□ Phlebitis
□ Psychiatric Disorder
□ Rash
□ Rheumatic Fever
□ Sleep Apnea
□ Stroke
□ Sciatica
□ Substance Abuse
□ Stomach Ulcer
□ Tuberculosis
□ Thyroid Problem
□ Unexplained Weight Loss
□ Warts

□ Other(s): _____

□ **NONE OF THE ABOVE**

□ Any metal or implants:_____

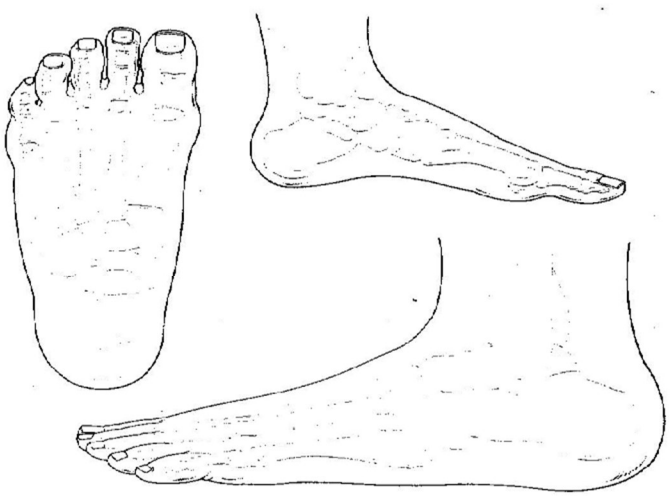
Previous Injuries:	**Previous Surgeries:**	**Previous Hospitalizations:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

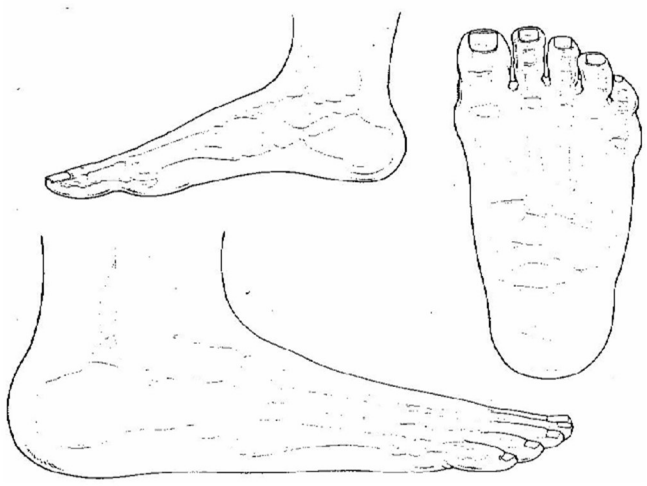
PATIENT'S CURRENT CHIEF COMPLAINTS

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 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:

□ Shooting Pain	□ Aching Pain
□ Throbbing Pain	□ Tenderness
□ Sharp Pain	□ Dull Pain
□ Burning Pain	□ Tingling
□ Itching	□ 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:

_____

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 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:

□ Shooting Pain	□ Aching Pain
□ Throbbing Pain	□ Tenderness
□ Sharp Pain	□ Dull Pain
□ Burning Pain	□ Tingling
□ Itching	□ 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 **OR** 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 **OR** 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 **OR** 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

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

Patient's **OR** Guardian's Signature _____ Date _____

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PHOTO CONSENT & RELEASE FORM

I the undersigned do hereby give permission for my photograph to be taken by Foot & Ankle Doctors, Inc. staff members to be used to evaluate my treatment and/or treated area to be used for the purpose of monitoring the healing progress. I am also allowing my picture to be taken for my chart.

Pictures of your treatment may be used for educational purposes, website, social media, or any other media. I understand that the material will not contain my name or any other personal identifying information therefore remaining anonymous.
By signing below, I confirm that I understand this consent and release form completely and that any questions I had have been asked and answered prior to signing.

Print Name: _____

Signature:_____ Date:_____

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Missed appointments and Cancellation Policy

We understand that you may need to reschedule appointments. When we make your appointment, please understand that we are reserving a time for you to see the provider. This courtesy makes it possible to give the best service at Foot & Ankle Doctors, Inc. Due to the huge pressure on our appointment list and the many people who do not turn up for their appointments each day, there is a charge for clients who fail to attend their appointment without a 24-hour notice.

If you have missed more than 3 appointments, you will be charged a $50.00 no show fee.

It is the patient responsibility to call our office at least 24 hours prior to scheduled appointment to cancel or reschedule.

We thank you for your understanding.

_____ _____

Patient Signature Date

_____

Patient Name

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.