Foot & Ankle Doctors, Inc.

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

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:** (____) _____-_____

Primary Language: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Shoe Size: _____ Weight: _____

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: ______

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COMPREHENSIVE MEDICAL HISTORY

Allergies:

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine/Shellfish
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other Allergies:
- ☐ NONE

Current Medication List:

____

____

____

____

____

____

____

____

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Please indicate if Mother or Father has had any of the following:

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

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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
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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
- ☐ 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**

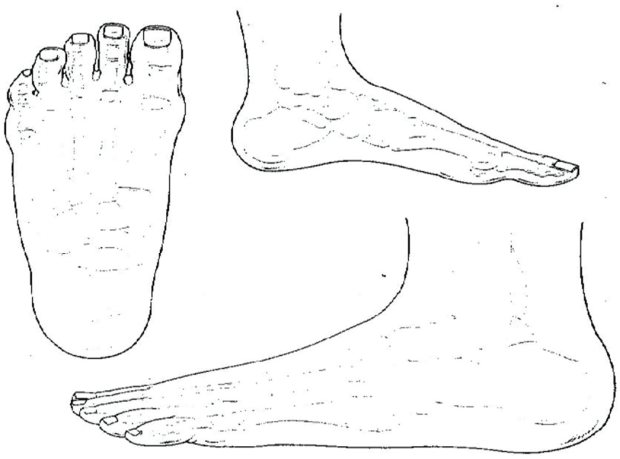
☐ Any metal or implants: _____

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

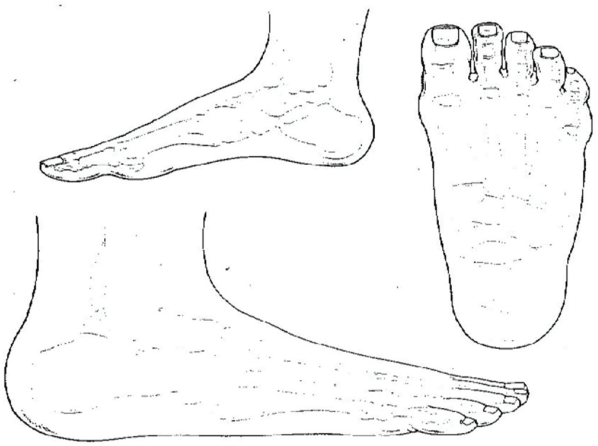
PATIENT'S CURRENT CHIEF COMPLAINTS

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 and Farshid Nejad, DPM, Nina Robinson, DPM are licensed and regulated by the board.

Patient's OR Guardian's Signature _____ Date _____