

**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: _____

COMPREHENSIVE MEDICAL HISTORY

Allergies:

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

Current Medication List:

Please indicate if Mother or Father 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 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

Do you have or have you ever been treated for:

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

☐ Other(s): _____

☐ **None of the above**

☐ Any metal or implants: _____

Previous Injuries:

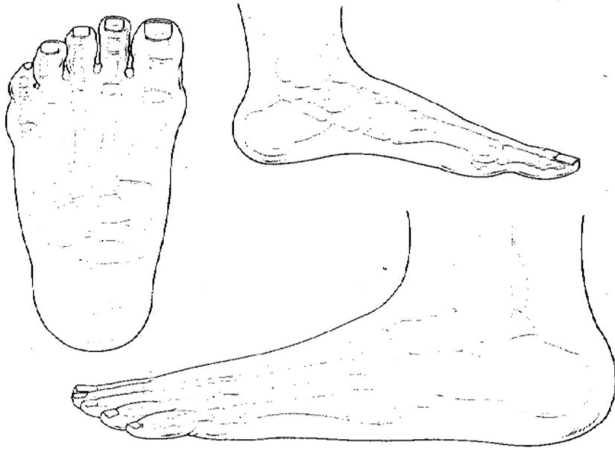
Previous Surgeries:

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



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:

- | | |
|---|--------------------------------------|
| <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**

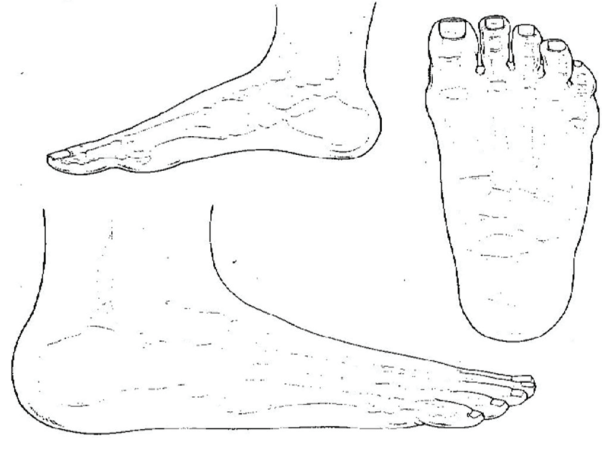
pain from my problem occurs:

○ while walking and/or ○ while not walking

○ and/or: _____

Previous medical treatment(s) or home remedies:

RIGHT FOOT



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:

- | | |
|---|--------------------------------------|
| <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:

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, Justin Gandomani, DPM, Jonathan Pirak DPM are licensed and regulated by the board.

Patient's OR Guardian's Signature _____ Date _____