



# 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

**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

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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: \_\_\_\_\_

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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Arthritis: <u>MOM or DAD</u>     | <input type="checkbox"/> Foot Problems: <u>MOM or DAD</u>       |
| <input type="checkbox"/> Birth Defects: <u>MOM or DAD</u> | <input type="checkbox"/> Heart Attack: <u>MOM or DAD</u>        |
| <input type="checkbox"/> Cancer: <u>MOM or DAD</u>        | <input type="checkbox"/> High Blood Pressure: <u>MOM or DAD</u> |
| <input type="checkbox"/> Diabetes: <u>MOM or DAD</u>      | <input type="checkbox"/> Stroke: <u>MOM or DAD</u>              |

**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:**

- 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:**

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**Previous Surgeries:**

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**Previous Hospitalizations:**

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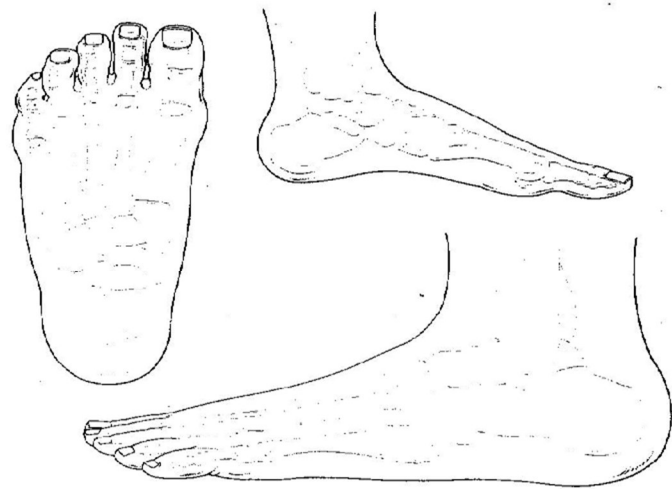
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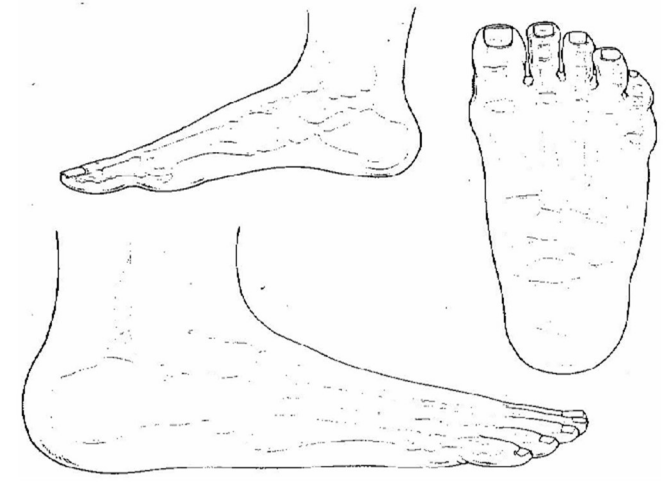
## PATIENT'S CURRENT CHIEF COMPLAINTS

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 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 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?**

\_\_\_ o days, o weeks, o months, o years ago **The**

**pain from my problem occurs:**

while walking and/or  while not walking

and/or: \_\_\_\_\_

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

\_\_\_\_\_

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None  Light  Moderate  Strong  Severe

**My Pain/Discomfort is:**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Shooting Pain  | <input type="checkbox"/> Aching Pain |
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**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](http://www.mbc.ca.gov)

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

Patient's **OR** Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_