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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: (____) _____-_____**

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

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

Primary Language: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Shoe Size: _____ Weight:_____

A1C: _____%

Race:_____ **Ethnicity:_____**

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

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

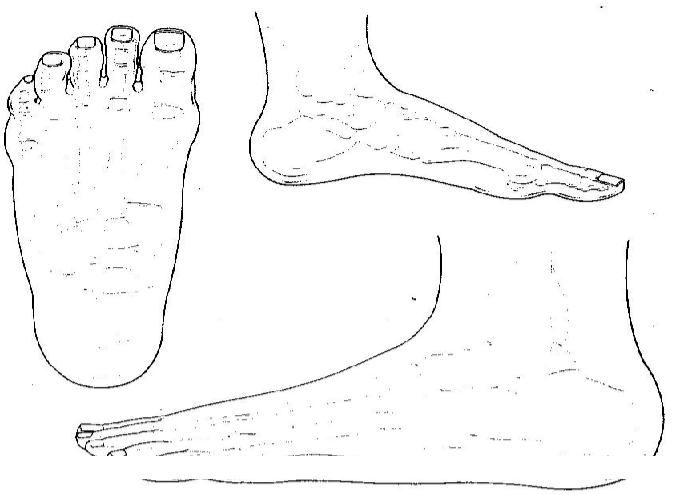
Alcoholic beverages? *(Circle one)*: None Rarely Moderately Daily Quit

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

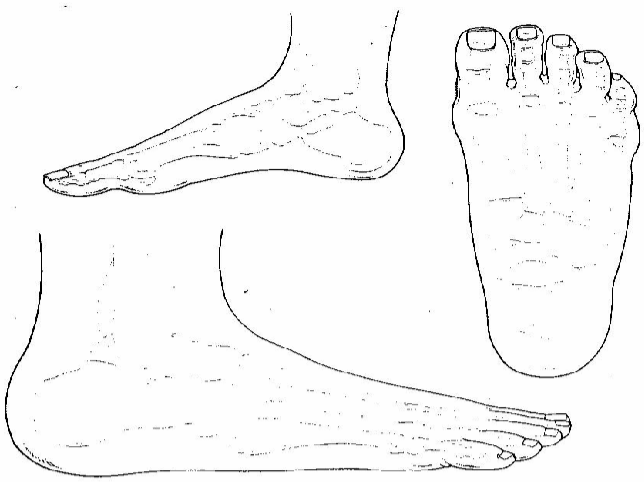
PATIENT'S CURRENT CHIEF COMPLAINTS

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 Chase Tamashiro 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:_____

Foot & Ankle Doctors, Inc. Beverly Hills

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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.

Any Missed appointment without proper notice will be charged a $75.00 fee.

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

We thank you for your understanding.

_____ _____

Patient Signature Date

_____

Patient Name