Foot & Ankle Doctors, Inc.

240 S. La Cienega Blvd. Suite 300
Beverly Hills, CA 90211
Telephone: (310) 652-3668 Fax: (310) 652-3669

Patient Information (Please Print)

Last Name: _____ MI: _____ First Name: _____

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

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

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

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

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

Pharmacy Phone: (____) ____-_____ Driver's License #: _____ Shoe Size: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

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

Relationship to the Patient: _____

INSURANCE INFORMATION

Patient's Relationship to Insured: ___ Self ___ Husband ___ Wife ___ Child ___ Other: _____

Name of Insured: _____ Date of Birth: ___/___/_____ Phone #: (____) _____-_____

Address (if different): _____

Insurance Company(ies) Name: _____

Group Number(s): _____ Policy Number(s): _____

COMPREHENSIVE MEDICAL HISTORY

Allergies:

□ Penicillin
□ Sulfa drugs
□ Aspirin
□ Codeine
□ Antibiotics
□ Iodine/Shellfish
□ Latex
□ Other Allergies: _____

Current Medication List:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have or have you ever been treated for:

□ Stroke
□ Sleep Apnea
□ Anemia
□ Diabetes
□ Gout
□ Sciatica
□ Arthritis
□ Epilepsy
□ Asthma
□ Hepatitis
□ Dark Urine
□ Cancer
□ Heart Attack
□ Vascular Disease
□ Poor Circulation
□ Kidney Disease
□ Osteoporosis
□ Lyme's Disease
□ Headaches
□ Nerve Disorder
□ Lung Disease
□ Liver Disease
□ Chronic Lt. Stool
□ Stomach Ulcer
□ High Blood Pressure
□ A Heart Condition
□ Eyes: Glaucoma/Manicular Deg.
□ Keloid/Thick Scar
□ Alzheimer's
□ Rheumatic Fever
□ Hearing/Ear Disorder
□ Psychiatric Disorder
□ Tuberculosis
□ Thyroid Problem
□ Unexplained Weight Loss
□ HIV/AIDS
□ Substance Abuse
□ Difficulty to stop bleeding
□ Polio
□ Breathing Problems
□ Phlebitis
□ Any implants in your body including, orthopedic, Cardiac, Cosmetic, et.
□ **NONE of these**
□ Other(s): _____

List relationship to you of family members who have had:

□ Diabetes _____
□ Arthritis _____
□ Stroke _____
□ Cancer _____
□ Other _____
□ Foot Problems _____
□ Heart Attack _____
□ High Blood Pressure _____
□ Birth Defects _____

COMPREHENSIVE MEDICAL HISTORY (continued)

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

Primary Language: _____

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

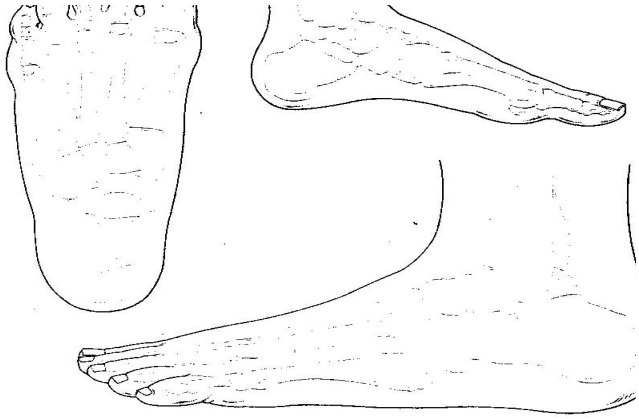
Have you had/been treated for:
□ Corns/Calluses
□ Leg or Foot Ulcers
□ Broken foot bone(s)
□ Hammer/Mallet toes
□ Cramps in legs/feet
□ Lower back pain
□ Gait (Walking) problems
□ Childhood foot problems
□ Rash
□ Warts
□ Fungal Nails
□ Neuroma
□ Broken Ankle
□ Bunions
□ Arch pain
□ Knee pain
□ In-toeing
□ Athlete's Foot
□ Ingrown nails
□ Foot Numbness
□ Ankle sprain
□ Flat feet
□ High arch feet
□ Heel pain
□ Toe walking
□ **NONE of these**

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

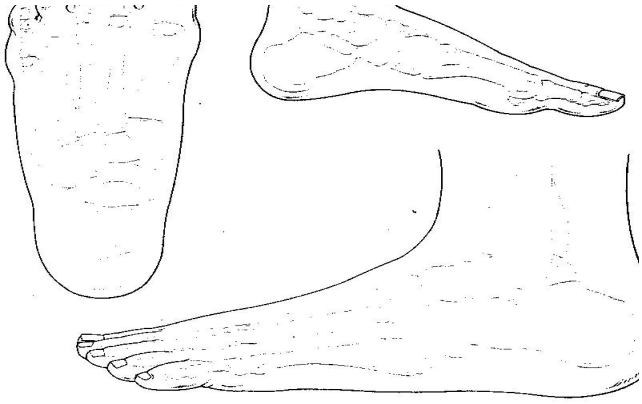
PATIENT'S CURRENT CHIEF COMPLAINTS

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

My first problem is:

□ On Left foot □ On Right foot □ On Both feet

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

My first problem is:

□ On Left foot □ On Right foot □ On Both feet

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/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/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/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, are licensed and regulated by the board.

Patient's/Guardian's Signature _____ Date _____