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

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:

□ 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 <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? ________________________________

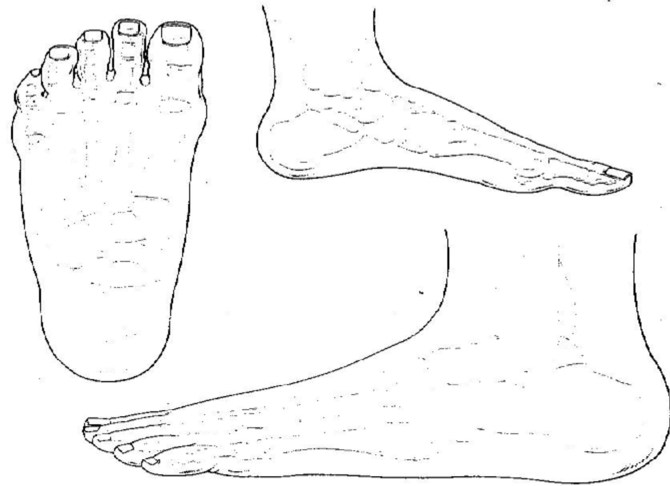
Alcoholic beverages? *(Circle one)*: None Rarely Moderately Daily Quit

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.

<u>**LEFT FOOT**</u>



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 …

____
____
____

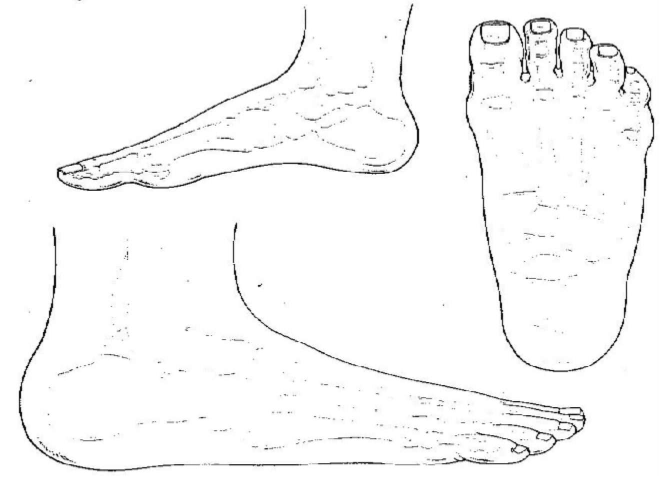
Is problem work related? □ Y □ N
Date of injury: ____ / ____ / ______
Date of report to employer: ____ / ____ / ______

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:
____

<u>**RIGHT FOOT**</u>



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, Fawzy Ibrahim 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:____________________

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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 $50.00 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

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**______________below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay forthe D.____________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**____________listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box foryou.
☐ **OPTION 1.** I want the **D.**____________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.**______________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.**____________listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare wouldpay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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