FOOT & ANKLE DOCTORS, INC

A PROFESSIONAL CORPORATION

David Dardashti, D.P.M. Farshid Nejad, D.P.M. AACFAS

PATIENT INFORMATION

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
- ☐ Phlebitis
- ☐ 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
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Psychiatric Disorder
- ☐ Tuberculosis
- ☐ Unexplained Weight Loss
- ☐ HIV/AIDS
- ☐ Substance Abuse
- ☐ Breathing Problems
- ☐ Hearing/Ear Disorder
- ☐ Difficulty to stop bleeding
- ☐ Thyroid Problem
- ☐ **NONE of these**
- ☐ Any implants in your body including, orthopedic, Cardiac, Cosmetic, etc

Others :

List relationship to you of family members who have

☐ Diabetes ☐ Arthritis ☐ Cancer ☐ Foot Problems ☐ Heart Attack

☐ High Blood Pressure ☐ Birth Defects ☐ Stroke

Others :

Do you smoke now? ☐ Yes ☐ No Packs/day Years

Did you ever smoke? ☐ Yes ☐ No Packs/day Years

If you quit, when did you do so?

Alcoholic beverages? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational Drugs? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Have you had/been treated for :

☐ Corns/Calluses ☐ Leg or Foot Ulcers ☐ High arch feet ☐ Broken foot bone(s)

☐ Hammer/Mallet toes ☐ Cramps in legs/feet ☐ Lower back pain ☐ Gait (Walking) problems

☐ Rash ☐ Warts ☐ Fungal Nails ☐ Childhood foot problems

☐ Neuroma ☐ Broken Ankle ☐ Bunions ☐ Arch pain

☐ Knee pain ☐ In-toeing ☐ Athlete's Foot ☐ Ingrown nails

☐ Foot Numbness ☐ Ankle sprain ☐ Flat feet

☐ Heel pain ☐ Toe walking ☐ **NONE of these**

Previous Injuries:

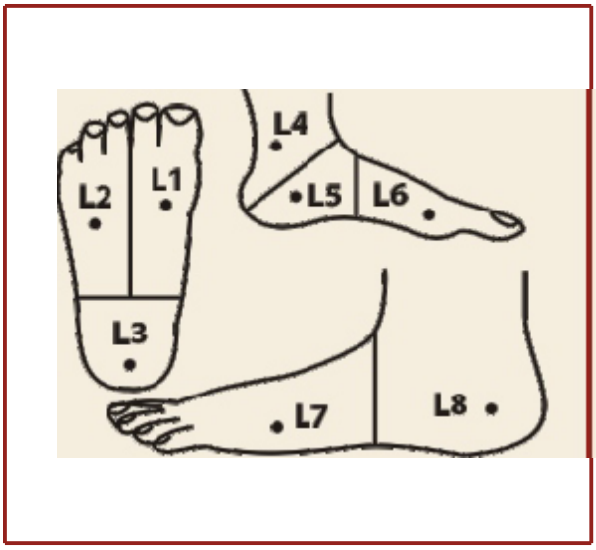
Previous Surgeries:

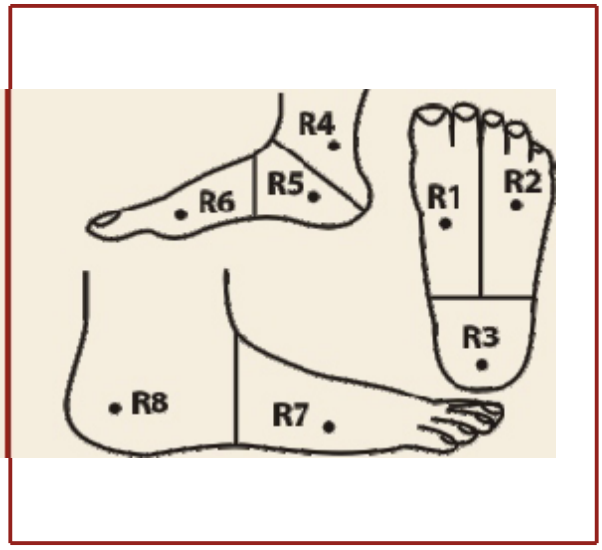
Previous Hospitalizations:

PATIENT S CURRENT CHIEF COMPLAINTS

Describe 1 or 2 main problems in greater detail below and check the checkbox the areas where you have each problem using numbers 1 and 2 to identify them.

(See Figure on next Page)





Left Foot

☐ L1 ☐ L2
☐ L3 ☐ L4
☐ L5 ☐ L6
☐ L7 ☐ L8

Right Foot

☐ R1 ☐ R2
☐ R3 ☐ R4
☐ R5 ☐ R6
☐ R7 ☐ R8

LEFT FOOT

1) Please check the location of your first problem or pain on the diagrams above with a number

A) 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? ☐ Yes ☐ No Date of injury : Date of report to employer :

B) Pain

Please indicate the severity of your pain or discomfort: ☐ None ☐ Light ☐ Moderate ☐ Strong ☐ Severe

My Pain/Discomfort is :

☐ Shooting Pain ☐ Throbbing Pain ☐ Sharp Pain ☐ Burning Pain ☐ Itching

☐ Tenderness ☐ DullPain ☐ Numbness ☐ Tingling ☐ Aching Pain

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 check the location of your first problem or pain on the diagrams above with a number

A) 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? ☐ Yes ☐ No Date of injury : Date of report to employer :

B) Pain

Please indicate the severity of your pain or discomfort: ☐ None ☐ Light ☐ Moderate ☐ Strong ☐ Severe

My Pain/Discomfort is :

☐ Shooting Pain ☐ Throbbing Pain ☐ Sharp Pain ☐ Burning Pain ☐ Itching

☐ Tenderness ☐ Dull Pain ☐ Numbness ☐ Tingling ☐ Aching Pain

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
- Hospital workers, nurses, aids and medical records department
- Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses, or
- Personal Religious designate Pharmacists, drug program personnel/
- Completion of disability forms
- 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: / /

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: / /