



Foot & Ankle
Doctors, Inc.
Beverly Hills

| Beverly Hills | Encino | Marina Del Rey | Los Alamitos | Pasadena | Rolling Hills Estates |
|--|--|---|--|---|---|
| 9100 Wilshire Blvd. Suite 280E Beverly Hills, CA 90212 P: (310) 652-3668 F: (310) 652-3669 | 16311 Ventura Blvd. Suite 650 Encino, CA 91436 P: (818) 981-1808 F: (818) 981-1816 | 8540 S. Sepulveda Suite 116 Los Angeles, CA 90045 P: (310) 652-3668 F: (310) 652-3669 | 10961 Cherry St. Los Alamitos, CA 90720 P: (562) 799-0992 F: (562) 799-0298 | 960 E Green St. Suite 254 Pasadena, CA 91106 P: (626) 793-0594 F: (310)652-3669 | 827 Deep Valley Dr. Suite 204 Rolling Hills Estates, CA 90274 P: (310) 652-3668 F: (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: _____

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 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 have or have you ever been treated for:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Flat feet | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Ankle sprain | <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Lyme's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fungal Nails | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gait (Walking) problems | <input type="checkbox"/> Neuroma |
| <input type="checkbox"/> Arch pain | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Nerve Disorder |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Broken foot bone(s) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Broken Ankle | <input type="checkbox"/> Hearing/Ear Disorder | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Cramps in legs/feet | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Corns/Calluses | <input type="checkbox"/> Hammer/Mallet toes | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heel pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Childhood foot problems | <input type="checkbox"/> High arch feet | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Chronic Lt. Stool | <input type="checkbox"/> In-toeing | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Diabetes : A1C _____ | <input type="checkbox"/> Ingrown nails | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Dark Urine | <input type="checkbox"/> Keloid/Thick Scar | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Difficulty to stop bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Eyes: Glaucoma/Manicular Deg | <input type="checkbox"/> Leg or Foot Ulcers | <input type="checkbox"/> 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? _____

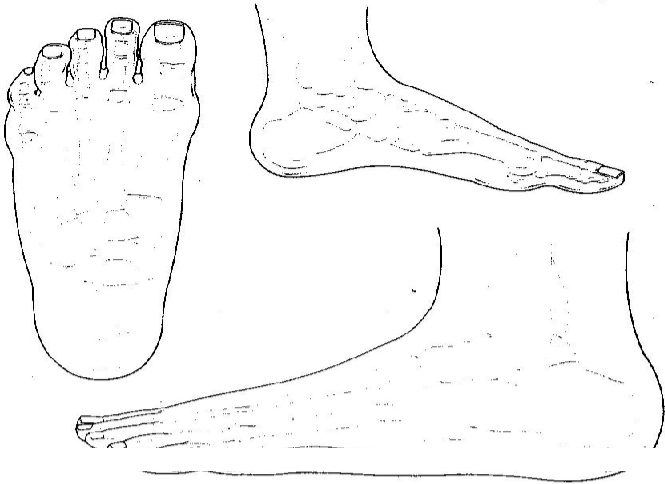
Alcoholic beverages? (Circle one): None Rarely Moderately Daily Quit

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

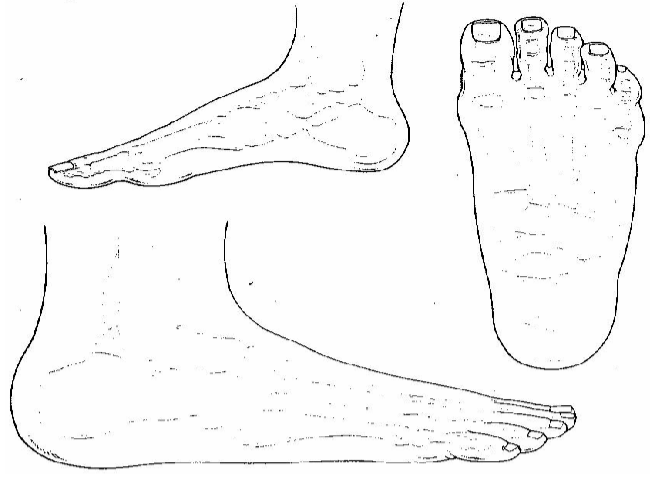
PATIENT'S CURRENT CHIEF COMPLAINTS

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: ____ / ____ / ____

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? ____

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

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? ____

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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Encino, CA 91436
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F: (818) 981-1816

Marina Del Rey

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F: (310) 652-3669

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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 \$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