PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: Last	First	M.I.	□ M □ F
Pharmacy Name & Address		Patient's preferred name?	
Patient's Address:			
City	State		Zip
Home Phone :	E-mail Address :		
Cell Phone :	Social Security #: - -	Birth date:	Age:
Employer:		Occupation:	
Emergency Contact:		Phone#:	

INSURANCE

Name of Insured (if other than self):			Birth Date:
Name of insured's employer:			Insured's work phone number:
Patient is:	□Subscriber	□Spouse	□Dependent

L&I

Date of Injury:		Type of Injury: □ Work	□ Auto □ Other
Has a claim been filed? □ Yes □ No	Claim #:	Where is claim filed?	
Cause of Injury:			

REFERRAL

Referred By: □ Friend _____ Web Search: □ Yelp □ Google □ Website

□ Doctor (name): _____ □ Other _____

Primary Care Physician and Clinic Name: Phone #:

SIGNATURE

Release of Benefits Information:

I authorize my insurance benefits to be paid directly to the doctor. I understand the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (if not signed payment due at time of service)

ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

AUTHORIZATION:

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees as follows:

1. Advanced Foot & Ankle, Inc. is granted permission to release to the insurance carrier, employer, their representatives or referring physician, any information I connection with any treatment rendered to patient, or in patient's behalf at any time such information is required.
2. Patient shall pay to Advanced foot and ankle, Inc. such sums as are due, or may become due, for services rendered to patient , it is understood that in the event patients insurance company (if there be any) does not make payment, or only a partial payment, this obligation shall be binding personally upon patient.
3. The undersigned patient or authorized individual acting on behalf of the patient understands and agrees to pay for services rendered to the above patient and If the account should be transferred to a collection agency/attorney for collection of a delinquent account shall pay reasonable collection costs or attorney fees.
4. I understand that the information sent to me via email from ADVANCED FOOT AND ANKLE CENTER will not be sent securely and will be unencrypted. I understand the risks associated including PHI may be read by unintended third party. I understand and still prefer to receive protected health information via unsecure communications via email; and that the office is not responsible for unauthorized access.

Patient Signature: _____ Date: _____

Patient's Name (First, Last)

Medical History – Confidential Information

Lower Extremity Medical History

What is/are the chief complaint(s) which brings you to our office for medical treatment?
(Include foot, ankle, leg, knee, and hip complaints)

Former foot and ankle physician:

Name: _____

Last Visit: _____

Any previous injuries or problems to the feet, ankles, or legs?

Symptoms

Which Side: ☐ Right ☐ Left ☐ Both

Type of Pain: ☐ Dull ☐ Achy ☐ Throbbing ☐ Burning ☐ Sharp ☐ Shooting

Area of Pain: _____

Onset: ☐ Slow ☐ Sudden ☐ Traumatic

Duration: ☐ Days ☐ Weeks ☐ Months ☐ Years

Has pain gotten: Better Worse Stayed the same

What aggravates condition?

☐ Walking ☐ Running ☐ Standing ☐ Shoes

What have you tried to help the pain?

☐ Changing shoes ☐ Anti-Inflammatories

☐ Decrease Activities

☐ Other: _____

How long does pain last? _____

Have you ever had a similar pain? ☐ Yes ☐ No

(Describe, including treatments received)

Exercise and Orthotics

In what athletic activities do you participate?

Days per week exercising? _____

Do you wear store-bought arch supports? ☐ Yes ☐ No

Do you wear custom orthotics? ☐ Yes ☐ No

If yes, who made them?: _____

How old are the orthotics?: _____

Allergies and Drug Intolerance

☐ Adhesive/Tape ☐ Aspirin ☐ Codeine

☐ Local Anesthetics ☐ Penicillin ☐ Iodine

☐ Seafood ☐ Sulfa

☐ No known drug allergies

☐ Other: _____

Medication

List all medications you are taking:

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Mental/Emotional

Eating Disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Psychiatric	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illness not previously listed:

Social History

Your occupation?

Do you currently smoke? ☐ Yes ☐ No

Are you a past smoker? ☐ Yes ☐ No

How much? _____ Packs/ _____

Years Smoked: _____

Drink alcohol? ☐ Yes ☐ No

How much: _____

Recreational Drugs? ☐ Yes ☐ No

What: _____

Pregnant or possibly pregnant? ☐ Yes ☐ No ☐ NA

General Medical History

Circle "Yes" or "No" to indicate if you or family members have any of the following:

Personal		Condition	Family Member
YES / NO		Anemia	YES
YES / NO		Arthritis:	YES
		Type: _____	
YES / NO		Artificial Heart	YES
YES / NO		Valve or Joints	YES
YES / NO		Asthma	YES
YES / NO		Back Problems	YES
YES / NO		Bleed Easily	YES
YES / NO		Cancer	YES
YES / NO		Chemical Dependency	YES
YES / NO		Chest Pain	YES
YES / NO		Circulatory Problems	YES
YES / NO		Diabetes	YES
YES / NO		Epilepsy	YES
YES / NO		Fibromyalgia	YES
YES / NO		Gout	YES
YES / NO		Heart Disease	YES
YES / NO		Hemophilia	YES
YES / NO		Hepatitis	YES
YES / NO		High Blood Pressure	YES
YES / NO		HIV Positive	YES
YES / NO		Kidney Problems	YES
YES / NO		Leg Cramps	YES
YES / NO		Liver Disease	YES
YES / NO		Lung/Respiratory	YES
YES / NO		Menopause	YES
YES / NO		Mental Illness	YES
YES / NO		Phlebitis/Clots	YES
YES / NO		Psoriasis	YES
YES / NO		Rheumatic Fever	YES
YES / NO		Stroke	YES
YES / NO		Thyroid Problem	YES
YES / NO		Tuberculosis	YES
YES / NO		Ulcer-Stomach	YES
YES / NO		Venereal Disease	YES
YES / NO		Weight Change:	

IF YES, how much?: + / - _____ lbs

NOTICE OF PRIVACY PRACTICES

Pedram Aslmand, D.P.M.
2840 Long Beach Blvd. Suite 205
Long Beach, CA 90806
(562) 426-0376

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____