PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #: (___) ___-_____ WORK #: (___) ___-_____ CELL #: (___) ___-_____

E-MAIL: _____

PRIMARY LANGUAGE: _____

RACE: _____ ETHNICITY: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (___) ___-_____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ CONTRACT # _____ GROUP # _____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

SECONDARY INSURANCE NAME : _____ CONTRACT # _____ GROUP # _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY
TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OSTEO ARTHRITIS ☐ OTHER _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

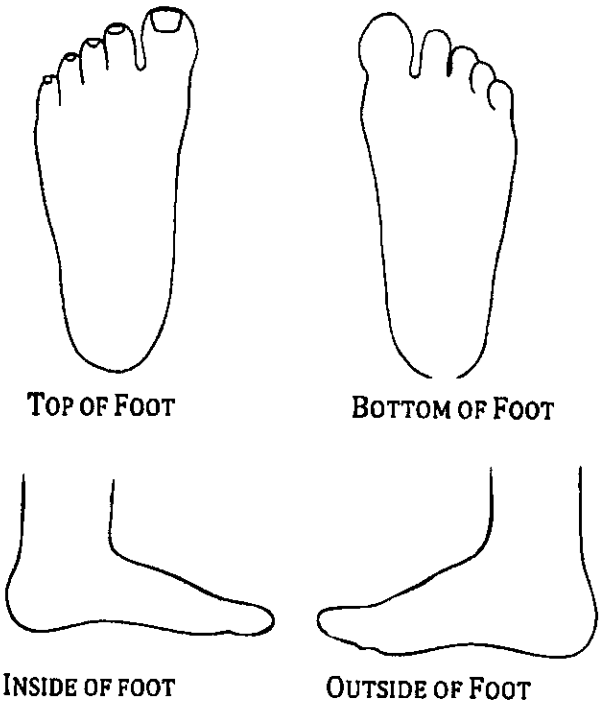
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	POOR CIRCULATION	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	RHEUMATIC FEVER	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SICKLE CELL DISEASE	Y	N
BLOOD CLOTS	Y	N	HIGH CHOLESTEROL	Y	N	SKIN DISORDER	Y	N
BLOOD TRANSFUSION	Y	N	KIDNEY DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LIVER DISEASE	Y	N	STROKE	Y	N
CANCER	Y	N	LOW BLOOD PRESSURE	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MIGRAINE HEADACHES	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

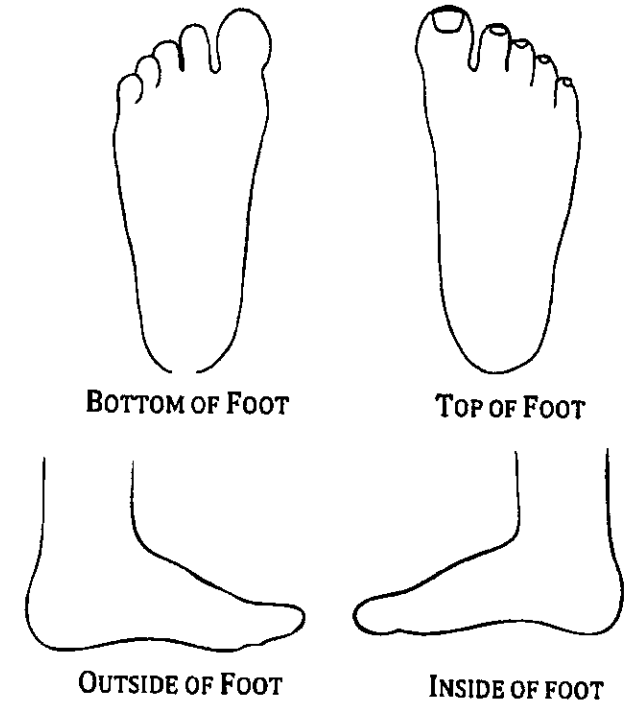
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT | BOTTOM OF FOOT | INSIDE OF FOOT | OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT | TOP OF FOOT | OUTSIDE OF FOOT | INSIDE OF FOOT

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I **UNDERSTAND THAT PACIFIC FOOT AND ANKLE ASSOCIATES DOE NOT TREAT WORK RELATED INJURIES, IF THIS INJURY IS WORK RELATED OR BECOMES A WORK-RELATED INJURY AT ANY TIME, I WILL BE LIABLE FOR ALL THE COSTS ASSOCIATED WITH THE TREATMENT.**

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

Last _____ First	Date: _____	☐ New Patient ☐ Update from: _____

FINANCIAL AGREEMENT

Patient Name:

Primary Insurance	Secondary Insurance
Subscriber Name:	**Subscriber Name:**
Insurance Company:	**Insurance Company:**
Policy #:	**Policy #:**
Group #:	**Group #:**
Subscriber Date of Birth:	**Subscriber Social Security #:**

FINANCE AGREEMENT FOR TREATMENT

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payments of benefits. I understand that fees for service are payable at the time of service unless other arrangements are made in advance. It is my responsibility to pay any deductibles or coinsurance. It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more then sixty (60) days for payment. After sixty (60) days, you will be billed for any outstanding balances on your account. All outstanding balance are due thirty (30) days from the statement date.

ACCOUNT TERMS & PAYMENTS FOR SUPPLIES & SERVICES

All accounts with balances which are past due 30 days or more will have a monthly finance charge of 2.5% applied until amount is paid in full. There will also be a monthly charge of rebilling and account maintenance of $20.00 which will be added to the balance. Any returned checks will be assessed a $35.00 charge in addition to the unpaid balance and your account will automatically be placed as an overdue account, under which a finance charge will be assessed. Any remaining past due balances will be forwarded to collections and an attorney fee and/or collection fee will be applied to the amount owed. If any appointment is missed or not cancelled within 24 hours of the scheduled appointment time, $40.00 will be applied to the account, which the patient will be responsible for.

CONSENT FOR TREATMENT

I certify that the above information is true and correct to the best of my knowledge and I give Edwin Oghoorian, DPM, his associates, his residents, and/or his medical students permission to administer any medications or anesthesia, take pictures, and administer and perform such procedure(s), surgical procedure(s), casting, or manipulation procedure deemed medically necessary in the diagnosis and treatment of the foot and ankle. I also give permission to use any of my records for teaching, research, and publications or video taping or recording of any kind for the advancement of science and scientific medical knowledge.

SIGNATURE

_____	_____
Signature of Patient Date	Legal Guardian Relationship Date

ATTENTION PATIENTS

Effective January 1, 2008 we will no longer be doing insurance eligibility in our office. It is **YOUR** responsibility to call your insurance and find out about your benefits, co-pays, deductibles, and what is covered and what is not a covered benefit prior to your appointment. It is also your responsibility to find out if we are in network with your insurance or not. If you have any questions regarding this issue, please ask our receptionist to give you a flyer which explains the reason for this decision in detail.

THIS DOES NOT APPY TO MEDICARE AND MEDI-MEDI-CAL PATIENTS

PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____

PFAA HMO – PPO Form 2021

PACIFIC FOOT AND ANKLE ASSOCIATES, INC
150 W. FOOTHILL BLVD. SUITE F
SAN DIMAS, CA 91773
TEL: 626.385.3338 FAX: 626.914.4119

PATIENT COMMUNICATION AND RELEASE OF INFORMATION

Home Number: _____

Cell Number: _____

Work Number: _____

Email Address: _____

I, _____ would like to receive reminders via the following methods (check all that apply)

___ Email

___Call/Text: ____Cell ____ home ____Work

I, _____ would like my personal information regarding my care and treatment including labs, imaging, copies of notes, and release of medical records to the following people only. (check all that apply)

___ No one but me

___ My spouse Name of spouse: _____

___ My child Name of the child: _____

___ My parent(s) Name of the Parent(s) _____

___ Other: Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____