PACIFIC FOOT AND ANKLE ASSOCIATES, INC.
150 W. Foothill Blvd, Suite F
San Dimas, CA 91773
Phone: (626) 385-3338
Fax: (626) 914-4119

FOOT AND ANKLE HISTORY

Last _____ First _____ M.I. ___ Sex ____ Age _____

Date of Birth _____ SS#_____ Email: _____

Address: _____City_____State_____Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Spouse/ Cohabitant_____

Height_____ Weight _____ Shoe size _____ Occupation _____

Emergency Contact _____Phone _____ Relation _____

Primary Care Physician: _____ Phone _____

Pharmacy: _____ Phone: _____

How did you hear about us? (check one)

□ Doctor □ Internet/Google □ Friend/Family □ Insurance □ Social Media □ YouTube □ Other

_____

MAIN PROBLEM: (check all that apply)

□ Pain or aching □ Swelling □ Weakness □ Stiffness Deformity □ Bump □ Instability

□ Infection □ Ingrown Nail □ Other _____

LOCATION OF MAIN PROBLEM: _____

DURATION: _____ □ Days □ Weeks □ Months □ Years

DESCRIPTION OF ONSET: **(check all that apply)**

□ Born with □ Injury □ Repetitive use □ Work-related □ Fall □ Twist

□ Sports-related □ No Injury □ Other _____

SEVERITY OF THE PAIN: on a scale of 1-10 how would you rate the pain? _____

DISCRIPTION OF PAIN: □ Sharp □ Dull □ Aching □ Burning □ Throbbing □ Other: _____

MEDICAL PROBLEMS: **(check all that apply)**

□ Diabetes □ Blood Pressure □ Cholesterol □ Osteo Arthritis □ Rheumatoid Arthritis □ Poor circulation
□ Neuropathy □ Kidney Disease □ Liver Disease □ Dialysis

□ Other: _____

MEDICATIONS: _____

_____

ALLERGIES: □ Penicillin □ Sulfa □ Aspirin □ Other _____

SURGERIES OR HOSPITALIZATIONS: _____

_____

FAMILY HISTORY: **(check all that apply)**

□ Diabetes □ Heart Disease □ Lung Disease □ Kidney Disease □ Arthritis □ Cancer

□ Other _____

Do you smoke: □ Yes □ No I smoke ___ packs a day for ___ years

Do you drink: □ Yes □ No I have ____ drinks a ___ day ___ a week ___ socially

Do you use illicit drugs: □ Yes □ No I use the following drugs _____

Acknowledgement of Receipt of Notice of Privacy Practice

Our office staff is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:

Office of **Pacific Foot and Ankle Associates Inc.**

Name of Patient (Print) _____

_____ _____

Signature of Patient or Authorized Representative 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: _____

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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: _____