Devon Glazer, DPM Bahar Golshahi, DPM Kyle Hehe, DPM Sam Meyers, DPM Sam Nosrati, DPM



 26691 Plaza Ste. 201 23141 Moulton Pkwy Ste. 109

 Mission Viejo, CA 92691 Laguna Hill, CA 92653

PATIENTS’ INFORMATION

Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Legal Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave a message? Y/N

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave a message? Y/N Text Message Reminders: Y/N

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ M / F (circle one) SS#: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/**\_\_\_\_\_\_** (Please provide last 4 digits)

Relationship Status: Single/ Married/ Divorced/ Widowed/ Domestic Partnership

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission to speak or leave a message with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This will be in effect until revoked in writing.

REFERRING PHYSICIAN/PRIMAY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy & Location (cross streets):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INSURANCE (PLEASE CIRCLE ALL THAT APPLY)

I have provided my cards at my initial appointment to be scanned into my chart. \_\_\_\_\_\_\_Initial

MEDICARE/ PPO/ WORK COMP/HMO/ SELF-PAY/ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT NAMED ABOVE INCLUDING BUT NOT RESTRICTED TO DRUGS, MEDICINE, PERFORMANCE OF OPERATION AND CONDUCT OF LABORATORY, X-RAYS, OR OTHER STUDIES THAT MAY BE USED BY DR.GLAZER AND DR. NOSRATI, THEIR ASSISTANTS OR ANY OTHER QUALIFIED DESIGNANTE. I AGREE TO ARBITRATOR MEDIATION IN THE CASE OF DEBATE IN REGARDS TO TREAMENT. I CONSENT TO THE TAKING AND PUBLICATION OF ANY PHOTOGRAPHS DURING THE COURSE OF THIS TREAMENT FOR THE PURPOSE OF ADVANCING MEDICAL EDUCATION. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

SUBSCRIBER/INSURED SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HEALTH HISTORY**

Your Health History is **IMPORTANT**. Please answer all questions thoroughly.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_ Shoe size:\_\_\_\_\_\_\_

**Chief Complaint**

Why are you seeing the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­

Pain Level of Injury ( 0-10 where 0=none, 10=extreme): \_\_\_\_\_\_\_\_\_\_

Current problem is the result of a(n): Check all that apply Car Accident\_\_\_\_\_\_ Work Accident\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

 **Medication**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Reason** |
|  |  |  |
|  |  |  |
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**Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Circle all that apply**

 Diabetes High Blood Pressure Heart Disease Lung Disorders High Cholesterol Kidney Problems Prostate Problems Thyroid

 Anemia Arthritis Gout Liver Disease Psychiatric Stroke TB Hepatitis Seizure Bleeding Disorders Polio Multiple Sclerosis Eating Disorder STD's AIDS/HIV Low Blood Pressure

 Cancer Type & Current Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**

**Surgeries/Hospitalizations:**

|  |  |  |
| --- | --- | --- |
| **Surgery** | **Year** | **Outcome/Complications** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever had general anesthesia? No Yes

Have you ever had any problems with anesthesia? No Yes

 Please Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have sleep apnea? If yes are you using CPAP?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

Are you currently having or have you had problems with your:

**Circle/Describe all “Yes” Responses:**

Eyes No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Ears,Nose,Throat No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lungs, breathing No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Irregular Heart Beat No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Digestion No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Bowel Movement No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bladder Problem No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Bleeding Problems No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Balance Problem No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Numbness/Tingling No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blackout/Fainting No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Headaches No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psych No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Fevers/Chills No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pain No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Skin Issues No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Back Pain No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancies No Yes Number of Pregnancies: \_\_\_\_\_\_\_\_ Complications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activity Level**

How often do you exercise? What do you do for exercise?

Daily Weekly Monthly Rarely Never

**Social Habits**

Do you have a history of substance abuse? No Yes What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink Alcohol? No Daily 1-2 x/week 1-2 x/month 1-2 x/year

Currently Smoking? No Yes \_\_\_\_\_\_\_ Packs per day \_\_\_\_\_ for \_\_\_\_\_\_ years

Quit Smoking? \_\_\_\_\_\_\_ previously smoked \_\_\_\_\_\_\_\_ packs per day for \_\_\_\_\_\_\_ years.

Have you used other tobacco products? No Yes What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to tobacco in your household? No Yes

**Family History**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Age** | **Deceased/Alive** | **Medical Condition** |
| **Father** |  |  |  |
| **Mother** |  |  |  |
| **Brother** |  |  |  |
|  |  |  |
| **Sister** |  |  |  |
|  |  |  |  |
|  |  |  |

**I certify that the above information is correct to the best of my knowledge, I will not hold my Doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Late Appointment Cancellation**

 **No -Show Policy for Doctor Appointments and Surgery**

**To All Artisan Foot and Ankle Patients:**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment in advance, it prevents an injured or emergent patient form getting in to a preferred appointment time. **“NO SHOW”** appointments increase healthcare delivery costs and may affect your future health plan. Due to the amount of recent no shows and late appointments cancellations we are now establishing a policy that if you do not show or do not cancel in a 24 hour period you will be charged a fee of $50.00. This policy will be in effect immediately.

"NO SHOW" appointments increase healthcaredelivery costs and may affectyour future health plan. Due to the amount of recent no shows and late

appointments cancellations we are now establishing a policy that if you

I have read and understand the above statement.

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature

Date:

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name

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**Questions and Complaints**

If you want more information about our policy practices or has questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to you protected health information or in response to a request you made, you may complain to us using the contacted information below.

**Name of contact person:** Alyssa Hernandez **Telephone:** 949-272-0007 ext 7

**Email:** [**www.office@artisanfeet.onmicrosoft.com**](http://www.office@artisanfeet.onmicrosoft.com)

You also may submit a written complaint to the *U.S Department of Health and Human Services.*

We will provide you with the address to file your complaint with the *U.S Department of Health and Human Services* upon request. We support your right to protect the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or the *U.S Department of Health and Human Services.*

 X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature

Date:

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name