Babak Kosari DPM Inc.
Foot & Ankle Surgery

PATIENT REGISTRATION FORM

Please Fill Form Completely

Date:

Last Name:

First Name:

Middle INI:

Street Address

City: State: Zip: Birthplace:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

SSN: Age:

Date of Birth Gender: ☐ Male ☐ Female

Race (optional): ☐ White ☐ Black ☐ Asian

☐ Hispanic ☐ Caucasian ☐ Other

Emergency Contact Information:

Name and relationship:

Phone:

Guarantor Responsible for Bill:

Name and Phone:

Spouse Name and Employment Information:

Name:

Employer:

Occupation: Employer/Address:

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Between Jobs ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Insurance: Insured's Name:

Secondary Insurance: Insured's Name:

Insured's Date of Birth (mm/dd/yy): Insured's Date of Birth (mm/dd/yy):

Relation to Patient: Relation to Patient:

Accident / Injury?: ☐ Yes ☐ No Date of Injury (mm/dd/yy): Time of Injury ☐ AM ☐ PM

Receiving worker's compensation: ☐ Yes ☐ No Place of Injury:

Pharmacy Pharmacy Phone

Primary Care Physician: Phone: Referred by: Phone:

I hereby authorize the physicians of Babak Kosari, D.P.M. Inc., to furnish medical and surgical treatment as indicated and to knowledge instructions for follow-up care. I hereby authorize them to release my medical and/or other information or reports for insurance claims. I hereby assign payment directly to Babak Kosari, D.P.M., Inc. for services rendered as described on their itemized claim form. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any amount determined to be subscriber's responsibility. I understand that if the physician does not have a contract to participate with my insurance, I am responsible for the full amount of all charges. A Photostated or scanned /digital copy of this authorization shall be considered as effective and valid as the original. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I ALSO CERTIFY THAT I HAVE READ AND UNDERSTAND THE HIPPA PATIENT CONSENT FORM.
PLEASE BE ADVISED THAT ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

Patient/Guardian Name: _____ Signature: _____ Date: _____

HIPPA PATIENT CONSENT FORM
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS SUMMERY CAREFULLY.

1. OUR LEGAL DUTY

We are required by law to protect the privacy of your health information, to provide a notice concerning privacy practices, to follow the privacy practices that we describe in our Notice of Privacy, and seek your acknowledgement of receipt of this notice.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you and how you can get access to this information. Our notice contains a Patient's Rights section describing your rights under the law.

You have the right to review and request a copy of our Notice of Privacy Practices before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

2. How we may use and disclose your health information:

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. For example, your health information may be shared with other providers to whom you are referred. You have the right to revoke this consent by requesting that in writing. However, such revocation shall not affect any disclosure we have already made in reliance upon your prior consent. The Practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPPA).

3. Your Rights:

You have the right to look at or get a copy of your health information, and if you request a copy, we may charge you a fee. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operation. We are not required to agree to this restriction, but if we do we shall honor the agreement. You may also request that we correct the information or add any missing information.

4. Privacy Complaints:

If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with the decision we have made about access to your health information, you may contact our Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

The patient understands that:

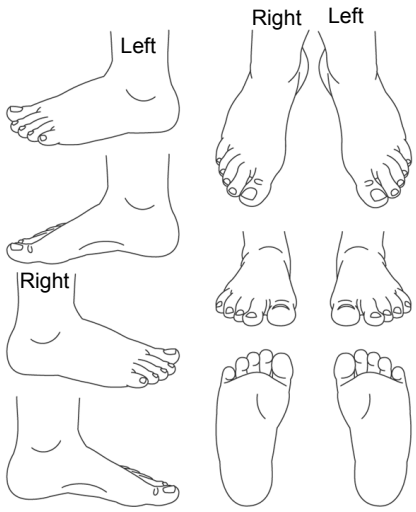
1. Protected health information may be disclosed or used for treatment, payment, or health related operations.
2. Our Practice has a Notice of Privacy Practices and that you the patient have the opportunity to review this notice.
3. The Practice reserves the right to change this Notice of Privacy Practices.
4. The patient has the right to restrict the uses of their information but the Practice does not have to to agree to these restrictions.
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
6. The Practice may condition receipt of treatment upon the execution of this consent.
7. If you have any questions or complaints, please contact our Privacy Officer.

Privacy Officer: Babak Kosari, D.P.M.

Patient/Guardian Name: _____ Signature*: _____ Date: _____

Last Name: _____ **First Name:** _____ **Middle INI:** _____ **Date:** _____

Reason for Today's Visit:



1. Describe Your Pain

- ☐ Sharp
- ☐ Tingling
- ☐ Dull
- ☐ Numbness
- ☐ Aching
- ☐ Burning
- ☐ Throbbing
- ☐ Other _____

2. Amount of Pain

- ☐ 0
- ☐ 1-2
- ☐ 2-4
- ☐ 4-6
- ☐ 6-8
- ☐ 8-10
- ☐ Constant
- ☐ Comes & Goes
- ☐ Occasional

3. Location

- ☐ Rt Foot
- ☐ Lt Foot
- ☐ Rt Heel
- ☐ Lt Heel
- ☐ Rt Ankle
- ☐ Lt Ankle
- ☐ Toe(s)_____
- ☐ Other

4. How Long

- ☐ ____Day(s)
- ☐ ____Week(s)
- ☐ ___Month(s)
- ☐ ____Year(s)

5. Condition

- ☐ SAME
- ☐ BETTER
- ☐ WORSE

6. What makes it worse?

- ☐ Walking
- ☐ Standing
- ☐ Pressure
- ☐ Shoes
- ☐ 1st Step in AM
- ☐ Other _____

7. What makes it better?

- ☐ Ice
- ☐ Rest
- ☐ Pain Meds
- ☐ Off of feet
- ☐ Wrap
- ☐ Soaking
- ☐ Other _____

8. Prior Treatments ☐ Yes ☐ No

If yes, when? _____

Where? _____

What? _____

Hospitalized? ☐ Yes ☐ No

Pain Medication? ☐ Yes ☐ No

I.V. Antibiotics?: ☐ Yes ☐ No

Antibiotic Pills? ☐ Yes ☐ No

☐ Xray ☐ MRI ☐ Surgery

Accident / Injury?: ☐ Yes ☐ No Date of Injury: _____

Place of Injury: _____

During Sport: ☐ Yes ☐ No At Home: ☐ Yes ☐ No

At Work: ☐ Yes ☐ No

Receiving worker's compensation: ☐ Yes ☐ No

Other Type of Injury, explain: _____

Athletic and Physical Activities:

- ☐ Biking
- ☐ Tennis
- ☐ Lacrosse
- ☐ Squash
- ☐ Walking
- ☐ Basketball
- ☐ Swimming
- ☐ Dancing/Aerobics
- ☐ Running
- ☐ Soccer
- ☐ Weight Lifting
- ☐ Football
- ☐ Hockey
- ☐ Golf

Level of Play:

- ☐ Professional
- ☐ College
- ☐ High School
- ☐ Recreational

REVIEW OF SYSTEMS

- ☐ Fever
- ☐ Chills
- ☐ Nausea
- ☐ Vomiting
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Leg Pain
- ☐ Lower Back Pain
- ☐ Burning Sensation
- ☐ Recent Fall
- ☐ Weakness
- ☐ Waking Up At Night
- ☐ Frequent Ankle Sprains
- ☐ Stomach Pain
- ☐ Unable to Take Meds

Have you ever had Orthotics:

☐ Yes ☐ No

Have you ever had general anesthesia?:

☐ Yes ☐ No

Have you ever had any problems with anesthesia?:

☐ Yes ☐ No

Last Name: _____ **First Name:** _____ **Middle INI:** _____ **Date:** _____

Please check any illnesses you and your family have or had:

Own:	Family:		Own:	Family:	
☐	☐	Diabetes	☐	☐	Joint Pain
☐	☐	High Blood Pressure	☐	☐	Bleeding Disorder
☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Stroke	☐	☐	Rheumatoid Arthritis
☐	☐	High Cholesterol	☐	☐	Anxiety
☐	☐	Arthritis	☐	☐	Depression
☐	☐	Liver Disease	☐	☐	Foot/Ankle Infection
☐	☐	Cancer	☐	☐	Mental Disease
☐	☐	Blood Clots	☐	☐	Vascular Disease
☐	☐	Stomach Ulcer	☐	☐	Dizziness/fainting
☐	☐	Numbness	☐	☐	Headache
☐	☐	Tingling	☐	☐	Stroke/TIA

☐ ☐ Other, Specify: _____

☐ ☐ Other, Specify: _____

☐ ☐ Other, Specify: _____

ALLERGIES: ☐ Yes (please list below) ☐ No

1. _____
2. _____
3. _____

MEDICATIONS:	Dosage:
1.	
2.	
3.	
4.	
5.	
6.	

Prior Surgery and Date (please list them):

1. _____
2. _____
3. _____

Complications from Prior Surgery:

☐ Yes ☐ No

If Yes, please explain:

_____

SOCIAL HISTORY

Do you smoke?: ☐ Yes ☐ No If yes, how long? (years) _____

Do you drink alcohol?: ☐ Yes ☐ No If yes, how long? (years) _____

How Often? ☐ Daily ☐ Weekly ☐ Monthly

Notes: