LOS ANGELES INSTITUTE OF FOOT & ANKLE SURGERY, INC.

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NAME _____ DATE _____

PHARMACY: _____

PHARMACY PHONE #: _____

ALLERGIES AND MEDICATIONS

ALLERGIES:

MEDICATION _____ TYPE OF REACTION _____
MEDICATION _____ TYPE OF REACTION _____
MEDICATION _____ TYPE OF REACTION _____
OTHER SUBSTANCES _____ TYPE OF REACTION _____
OTHER SUBSTANCES _____ TYPE OF REACTION _____
OTHER SUBSTANCES _____ TYPE OF REACTION _____

MEDICATIONS:

MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____
MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____
MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____
MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____
MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____
MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____
MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____
MEDICATION _____ DOSAGE _____ STARTED _____ D/C _____

PATIENT NAME: _____ DATE: _____

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

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

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

SOCIAL SECURITY # _____

HOME PHONE #: (___) ___-_____ YES NO

WORK PHONE #: (___) ___-_____ YES NO

CELL PHONE #: (___) ___-_____ YES NO

E-MAIL: _____ YES NO

MAY WE LEAVE A MESSAGE? YES NO

MAY WE TEXT TO CONFIRM YOUR APPOINTMENT? YES NO

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 #: (___) ___-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

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

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

LOS ANGELES INSTITUTE OF FOOT AND ANKLE SURGERY

PATIENT NAME: _____ **DATE:** _____

WHO REFERRED YOU TO US?_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

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

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

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

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER

_____

PATIENT NAME: _____ DATE: _____

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS (FOR PHYSICIAN USE): _____

_____

_____

_____

PAST MEDICAL HISTORY:

DIABETES (HOW MANY YEARS)_____ INSULIN-CONTROLLED (HOW MANY YEARS?)_____

ASTHMA/BRONCHITIS	HIGH BLOOD PRESSURE	HEART ATTACK/ANGINA
ARTHRITIS	HIGH CHOLESTEROL	STOMACH ULCERS
GOUT	BLEEDING PROBLEMS	THYROID DISEASE
STROKE	HEPATITIS/LIVER PROBLEMS	SEIZURES

OTHER_____

ARE YOU CURRENTLY RECEIVING MEDICAL CARE? NAME OF DOCTOR _____

PAST SURGICAL HISTORY:

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

INJURIES/ACCIDENTS/ BROKEN BONES: _____

SOCIAL HISTORY

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

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ 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 _____

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

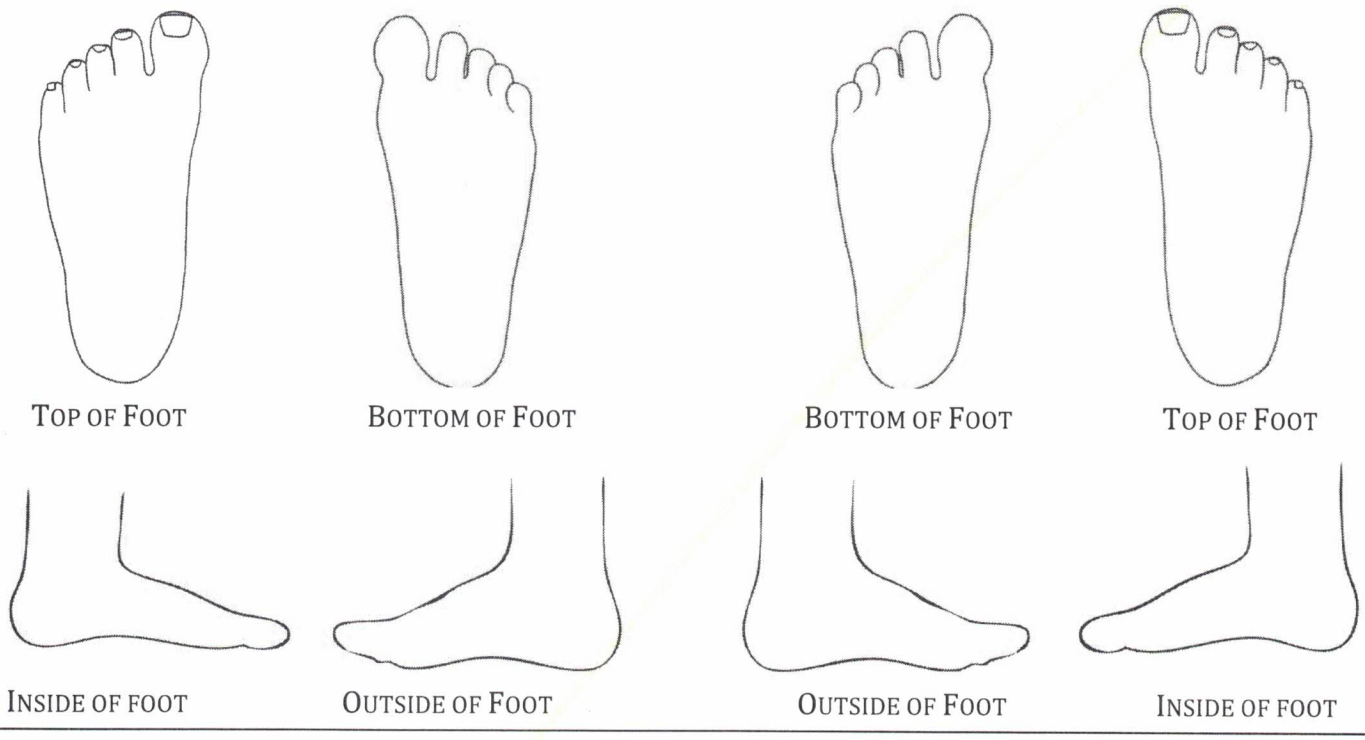
FAMILY HISTORY

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
☐ OTHER _____

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS **HAVE YOU EXPERIENCED (PLEASE CIRCLE)**

HEADACHES	DIZZINESS	WEIGHT GAIN/LOSS	DIFFICULTY BREATHING
CHEST PAIN	COUGHING	POOR CIRCULATION	GALLSTONES
PALPITATIONS	HEARTBURN	PAINFUL URINATION	SEIZURES
VOMITING	DIARRHEA	VISION PROBLEMS	DEPRESSION
WEAK MUSCLES	PARALYSIS	UPSET STOMACH	BLADDER INFECTION
JOINT PAIN	KIDNEY PROBLEMS	CHANGES IN URINARY FREQUENCY OR URGENCY	



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)*

LOS ANGELES INSTITUTE OF FOOT AND ANKLE SURGERY

PATIENT NAME: _____ **DATE:** _____

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.

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

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

LOS ANGELES INSTITUTE OF FOOT AND ANKLE SURGERY

TO OUR PATIENT: _____

RE: "**YOUR INSURANCE COVERAGE"**

If you have a managed care plan such as HMO,PPO, EPO, POS and MEDICARE plan you can be seen as an "out of network" patient. However, in many cases, you may need to meet a deductible, and reimbursement may be at a lower percentage, depending on the quality of your Insurance Carrier. To ease the financial burden courtesy discounts are frequently provided.

You may wish to contact your Insurance for additional information regarding benefits.

Your signature will indicate that you understand and agree with the above.

SIGNATURE _____

DATE _____

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23911 Calgrove Blvd• Santa Clarita• CA 91321

LOS ANGELES INSTITUTE OF FOOT AND ANKLE SURGERY

TO OUR PATIENT: _____

RE: **DURABLE MEDICAL EQUIPMENT**

Please be aware our office has purchase Durable Medical Equipment to provide to our patient.
There is an uncertainty and occasional low reimbursement from Medicare and all other insurance carriers. In light of this fact, you will be billed for any unpaid balance following payment by your insurance carrier.

The fee charged represents cost of the equipment plus a 10-20% handling fee.

Your signature will indicate that you understand and agree with the above.

SIGNATURE _____

DATE _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name:_____ **Date of birth:**_____
Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**
Or specify one or more of the following:

☐ Operative Reports	☐ X-rays
☐ Progress Notes	☐ Billing and Claim Records
☐ Laboratory	☐ (Other – specify) _____

This information is to be used/disclosed for the following purposes(s) only: _____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** _____ **Initials**

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____
Relationship to the patient (if applicable):_____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**