Empire FOOT AND ANKLE CENTER

Rabin Beral, DPM
Farid Didari, DPM,AACFAS
Lisa Breshears, DPM,AACFAS

Patient Information

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name
_____
First Name Middle Name
Address _____
City _____
State _____ Zip _____
Email _____
Sex ☐M ☐F Age _____ Birthdate _____
Married Widowed Single Minor
Separated Divorced Partnered for ____ Year
Patient/Employer School _____
Employer/School Address _____
_____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____ SS# _____
Spouse's Employer _____
Whom may we thank for referring you?_____

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Insurance

Who Is responsible for this account? _____
Relationship to patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ☐Yes ☐No
Subscriber's Name _____
Birthdate _____ SS #_____
Relationship to Patient _____
Insurance Co. _____
Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and. ii applicable. Medigap benefits, be made either to me or on my behalf to _____
Name of Doctor Or Clinic
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services. My Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneiiciary, Guardian or Personal Representative

_____
Please print name of Beneiiciary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneiiciary

Podiatric History

What is the chief complaint for which you came to be treated? (Included tools, ankle, knee, thigh, and hip complaints.)

_____
_____
_____

Have you ever been to a Podiatrist before?
☐Yes ☐No
If yes, please list.

Is there any personal or family history of diabetes?
☐ Yes ☐ No
Your occupation _____
Cigarette/Tobacco use _____
Years smoked _____
Athletic activities in which you participate (please list and indicate frequency)
_____

Shoe size _____ HT _____ WT _____
Please indicate which foot problems you now have or have had in past.

	Yes	No
Ankle Pain	☐	☐
Athlete's Foot	☐	☐
Bunions	☐	☐
Corns and Calluses	☐	☐
Cramps or Numbness in Feel or Legs	☐	☐
Flat Feet	☐	☐
Foot or Leg Cramps	☐	☐
Heel Pain	☐	☐
Ingrown toenails	☐	☐
Plantar Warls	☐	☐

Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Rash	☐	☐
Allergies to Anesthetics	☐	☐	Eye Problems	☐	☐	Respiratory Disease	☐	☐
Allergies to Medicine or Drugs	☐	☐	Fainting	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Foot or Leg Cramps	☐	☐	Shortness of Breath	☐	☐
Angina	☐	☐	Gout	☐	☐	Sinus Problems	☐	☐
Arthritis	☐	☐	Headaches	☐	☐	Special Diet	☐	☐
Artificial Heart Valves or Joints	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Hemophilia	☐	☐	Swelling in Ankles, Feet	☐	☐
Back Problems	☐	☐	Hepatitis or Jaundice	☐	☐	Swollen Neck Glands	☐	☐
Bleeding Disorder	☐	☐	High Blood Pressure	☐	☐	Tired Feet	☐	☐
Cancer	☐	☐	Kidney Problems	☐	☐	Tuberculosis	☐	☐
Chemical Dependency	☐	☐	Liver Disease	☐	☐	Ulcers	☐	☐
Chest Pain	☐	☐	Low Blood Pressure	☐	☐	Varicose Veins	☐	☐
Chronic Diarrhea	☐	☐	Neuropathy	☐	☐	Venereal Disease	☐	☐
Circulatory Problems	☐	☐	Phlebitis	☐	☐	Weight Loss, unexplained	☐	☐
Diabetes	☐	☐	Psychiatric Care	☐	☐			
Ear Problems	☐	☐	Radiation Treatment	☐	☐			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

Medications

Include prescription, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

Allergies

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafood
☐ Demerol	☐ Sulfa
☐ Iodine	

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

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Patient Information

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name
_____
First Name Middle Name
Address _____
City _____
State _____ Zip _____
Email _____
Sex ☐M ☐F Age _____ Birthdate _____
Married Widowed Single Minor
Separated Divorced Partnered for ____ Year
Patient/Employer School _____
Employer/School Address _____
_____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____ SS# _____
Spouse's Employer _____
Whom may we thank for referring you?_____

Phone Numbers

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IN CASE OF EMERGENCY, CONTACT

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Relationship to patient _____
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Group # _____
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I request that payment of authorized Medicare benefits and. ii applicable. Medigap benefits, be made either to me or on my behalf to _____
Name of Doctor Or Clinic
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services. My Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

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_____
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_____ _____
Date Relationship to Beneiiciary

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Corns and Calluses	☐	☐
Cramps or Numbness in Feel or Legs	☐	☐
Flat Feet	☐	☐
Foot or Leg Cramps	☐	☐
Heel Pain	☐	☐
Ingrown toenails	☐	☐
Plantar Warls	☐	☐

Empire FOOT AND ANKLE CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I as provided a copy of the Notice of Privacy Practices and that I read (or had the opportunity to read if I chose) and understood the notice.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorize Representative (if applicable)

_____

Signature

Phone (909) 946-6643 -Fax (909) 946-6130

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INFORMATION PERSONAL

Apellido _____ Nombre _____ Inicial _____ MF
Fecha de Nacimiento _____/_____/_____ Numero de Seguro Social _____-_____-_____
Direction _____
Ciudad _____ Estado _____ Codigo Postal _____ Tel (_____) _____-_____
Empleado _____ Tel (_____) _____-_____
Direccion _____ Ciudad _____ Estado _____ Codigo Postal _____

INFORMATION DE ASEGURANZA

1)
Nombre de Aseguranza _____
Numero de ID _____ Numero de Grupo _____
Nombre de Responsable _____
Fecha de Nacimiento _____/_____/_____ Seguro Social _____-_____-_____
Empleado _____ Tel (_____) _____-_____
Direction _____ Ciudad _____ Estado _____ Codigo Postal _____
2)
Nombre de
Aseguranza _____
Numero de ID _____ Numero de Grupo _____
Nombre de Responsable _____
Fecha de Nacimiento _____/_____/_____ Seguro Social _____-_____-_____
Empleado _____ Tel (_____) _____-_____
Direction _____ Ciudad _____ Estado _____ Codigo Postal _____

EN CASO DE EMERGENCIA

Nombre _____ Relacion con Paciente _____
Direccion _____ Ciudad _____ Estado _____ Codigo Postal _____
Tel (_____) _____-_____

Estoy de acuerdo en aceptar la responsabilidad rentistica por los servicios al paciente y autoizar pagos deprate de cualquier tipo de beneficio medico al Dr. Bledsoe

Firma del Paciente o Responsable _____

Fecha _____