



Patient Informa	ation		Insurance
Date			e for this account?
SS/HIC/Patient ID #	*	Relationship to pa	tient
Patient Name		Group #	
Last Name		Is patient covered	by additional insurance?  SS # tiont
First Name	Middle Name	Birthdate	SS #
Address		Neialionship to Fa	tient
City		Group #	
State Zip	-	INICI IDANICE ACC	IGNMENT AND RELEASE
		I certify that I have	e insurance coverage with
Email Sex		and assign directly	/ to Dr al
Married Widowed Single		insurance benefits	s, if any, otherwise payable to me for service
Separated Divorced Partne	ered for Year		stand that I am financially responsible for all or not paid by insurance. I authorize the use
Patient/Employer School			all insurance submissions.
Employer/School Address			
<u></u>			l doctor may use my health care information such information to the above-named
Employer/School Phone ()			ny(ies) and their agents for the purpose of
Spouse's Name		obtaining paymen	t for services and determining insurance
Birthdate SS#			nefits payable for related services. This
			hen my current treatment plan is completed he date signed below.
Whom may we thank for referring you?		or one year from t	ne date signed below.
		MEDICARE/MEDI	GAP AUTHORIZATION
Phone Numb	ers	I request that pour	ment of authorized Medicare benefits and.
		ii applicable, Medi	gap benefits, be made either to me or on
Home Phone ()		my behalf to	Name of Doctor Or Clinic
Cell Phone ()		To the extent norm	Name of Doctor Or Clinic
Cell Filotie ()			nitted by law, I authorize any holder of formation about me to release to the Cente
Best time and place to reach you			Medicaid Services. My Medigap insurer, and
IN CASE OF EMEROPHON CONTACT	-22		formation needed to determine these s for related services.
IN CASE OF EMERGENCY, CONTACT		benefits or benefit	s for related services.
Name			
		Signature of Ben	eiiciary, Guardian or Personal Representative
Relationship		_	
Home Phone ()		Please p	orint name of Beneiiciary, Guardian or
	**		Personal Representative
Work Phone ()			
		Date	Relationship to Beneiiciary
	Dadiatri	. Hiotowy	
	rouiatri	c History	
What is the chief complaint for which	Is there any personal	or family history of	Shoe size HT WT
you came to be treated? (Included tools,	diabetes?		Please indicate which foot problems you now have or have had in past.
ankle, knee, thigh, and hip complaints.)	☐ Yes ☐ No		Yes N
			Ankle Pain
- E	Your occupation		Athlete's Foot
£	Cigarette/Tobacco use		Corns and Calluses
	Years smoked		Cramps or Numbness in Feel or Legs ☐
Have you ever been to a Podiatrist before?	Athletic activities in wh	nich you participate	Flat Feet
☐ Yes ☐ No (please list and indica			Foot or Leg Cramps [ Heel Pain [
	(F. Caso not and malod		Ingrown toenails
If yes, please list.	7		Plantar Warls

Medical History  Place a mark on "Yes" or "No" to indicate if you have had any of the following:    Yes				Madiaal Ui	-4-	163.7			
Ves No									
Allergies to Anesthetics   Eplepsy   Respiratory Disease   Allergies to Medicine or Drugs   Fairting   Respiratory Disease   Respiratory Disease   Anemia   Foot or Leg Cramps   Shortness of Breath   Anemia   Gout   Sinus Problems   Anemia   Shortness of Breath   Anemia   Shortness of Breath   Anemia   Shortness of Breath   Shortness of Breath   Anemia   Shortness of Breath   Shortness of Breath   Anemia   Shortness of Breath   Shortness   Shortness of Breath   Shortness of Breath	Place a mark on "Yes" or "N	lo" to	indicat	te if you have had any of	f the f	ollowi	ing:		
Allergies to Medicine or Drugs							-		
Allergies to Medicine or Drugs   Fainting   Returnatic Fever   Reduration Fever   Returnation   Retu					_	_		_	_
Anemia	_	_		•					_
Angine				•	_				_
Arthritis   Head Claseas   Special Diet   Artificial Heart Valves or Joints   Heart Disease   Stroke   Artificial Heart Valves or Joints   Heart Disease   Stroke   Artificial Heart Valves or Joints   Heart Disease   Swelling in Ankles, Feet   Back Problems   Hempophilia   Swelling in Ankles, Feet   Back Problems   Tried Feet   Radional Problems   Tuberculosis   Radional Problems   Tuberculosis   Radional Problems   Radional Proble								_	
Asthma	_								
Asthma   Heaphilia   Swelling in Ankles, Feet   Back Problems   Heaphilis or Jaundice   Swelling in Ankles, Feet   Back Problems   Heaphilis or Jaundice   Swelling in Ankles, Feet   Back Problems   Tired Feet   Back Problems   Tired Feet   Back Problems   Tired Feet   Back Problems   Tuberculosis   Back Problems   Back Pr							•		_
Back Problems									_
Bleeding Disorder				•			_		_
Cancer						_			_
Chemical Dependency   Liver Disease   Ulcers   Chest Pain   Low Blood Pressure   Varicose Veins   Chronic Diarrhea   Neuropathy   Venereal Disease   Circulatory Problems   Phiebitis   Weight Loss, unexplained   Diabetes   Psychiatric Care	_			•				<del></del>	_
Chest Pain		_	_	•					_
Chronic Diarrhea   Neuropathy   Venereal Disease   Disease   Neuropathy   Neuropathy   Venereal Disease   Neuropathy   Neuropathy   Venereal Disease   Neuropathy   Neuropathy   Venereal Disease   Neuropathy   Neur					_				_
Circultory Problems   Phlebitis   Weight Loss, unexplained   Paychiatric Care   Paychiatr					_				_
Diabetes   Psychiatric Care   Radiation Treatment   Psychiatric Care   Radiation Treatment   Psychiatric Care   Radiation Treatment   Psychiatric Care   Radiation Treatment   R				• •				_	_
Ear Problems	· · · · · · · · · · · · · · · · · · ·	_	_		_		Weight Loss, unexplained	Ш	Ш
Hospitalization other than for the surgeries listed				•	_				
Family physician Last visit date	Surgeries you have had								
Pharmacy Name(s)	Family physician  Are you now, or have you bee  If yes, please explain  Me	dic	der any	other doctor's care for any	reaso	on ove	Last visit dateer the past two years?  Allergies  Adhesive/Tape	cal Anestl	□ No
Pharmacy Phone(s) (							Codeine Sea	afood	
Treatment Consent  I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perfrom such procedures upon me as the doctor deems necessary.  Signature of Patient, Parent, Guardian or Personal Representative  Date							Demerol Sul	fa	
Treatment Consent  I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perfrom such procedures upon me as the doctor deems necessary.  Signature of Patient, Parent, Guardian or Personal Representative  Date							lodine		
I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perfrom such procedures upon me as the doctor deems necessary.  Signature of Patient, Parent, Guardian or Personal Representative  Date	Do you take oral contraceptives?	∐ Y	′es ∐I	No					
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient	from such procedures upon me	as the	sion to the doctor	e doctor (and the doctor's as deems necessary.			esignated replacement) to adminis	ter and բ	0er-
	Please print name of Patier	nt. Pare	ent. Guard	ian or Personal Representative			Relationship to Patient		





Patient Informa	ation		Insurance				
Date		Who Is responsible	e for this account?				
SS/HIC/Patient ID #		Relationship to pa	tient				
Patient Name		Group #					
Last Name		1	by additional insurance?				
First Name	Middle Name	Birthdate	SS # tient				
Address			ment				
City		Group #	7				
State Zip	<del></del>		IGNMENT AND RELEASE insurance coverage with				
Email			Name of Insurance Company(ies)				
Sex DM DF Age Birthdate _		and assign directly	to Dr all all if it is not any, otherwise payable to me for services				
Married Widowed Single		rendered. I understand that I am financially responsible for all					
Separated Divorced Partne			or not paid by insurance. I authorize the use				
Patient/Employer School		of my signature or	all insurance submissions.				
Employer/School Address		The above-named	doctor may use my health care information				
Employer/School Phone ()			such information to the above-named				
Spouse's Name			ny(ies) and their agents for the purpose of t for services and determining insurance				
Birthdate SS#			nefits payable for related services. This				
Spouse's Employer			hen my current treatment plan is completed				
Whom may we thank for referring you?		or one year from the	ne date signed below.				
		MEDICARE/MEDI	GAP AUTHORIZATION				
Phone Numb	ers	I request that payr	nent of authorized Medicare benefits and.				
Homo Phono (		ii applicable. Medi	gap benefits, be made either to me or on				
Home Phone ()		my behalf to	Name of Doctor Or Clinic				
Cell Phone ()			nitted by law, I authorize any holder of				
Best time and place to reach you		for Medicare and I	formation about me to release to the Centers Medicaid Services. My Medigap insurer, and				
IN CASE OF EMERGENCY, CONTACT			formation needed to determine these s for related services.				
Name							
Bolotionobio		Signature of Ben	eiiciary, Guardian or Personal Representative				
Relationship							
Home Phone ()	**	Please p	orint name of Beneiiciary, Guardian or Personal Representative				
Work Phone ()							
		Date	Relationship to Beneiiciary				
	Podiatrio	History					
NAME at its the artist as over laint for outside			Ohan airea				
What is the chief complaint for which	Is there any personal	or family history of	Shoe size HT WT Please indicate which foot problems you now				
you came to be treated? (Included tools,	diabetes?		have or have had in past.				
ankle, knee, thigh, and hip complaints.)	☐ Yes ☐ No		Yes No Ankle Pain				
2	Your occupation		Athlete's Foot				
	Cigarette/Tobacco use		Bunions $\square$				
30	Years smoked		Corns and Calluses				
Have you ever been to a Redistrict before?	Athletic activities in wh		Flat Feet				
Have you ever been to a Podiatrist before?			Foot or Leg Cramps				
☐ Yes ☐ No	(please list and indicat	e trequency)	Heel Pain				
If yes, please list.	3		Plantar Warls				



## 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	



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

## INFORMATION PERSONAL

Apellido/	Nombre	Inicial	MF
Fecha de Nacimiento /	/ Numero de Seg	guro Social	_
Direction			
Ciudad Est	tado Codigo Postal	Tel ( )	
Direction Est Empleado	Tel (		
Empleado Direccion	Ciudad	Estado Codigo Postal	
,			
INFORMATION DE AS	SEGURANZA		
1)			
Nombre de Aseguranza			
Nombre de AseguranzaNumero de IDNombre de Responsable	Numero	de Grupo	
Nombre de Responsable  Fecha de Nacimiento / / / / / / / / / / / / / / / / / / /		•	
Fecha de Nacimiento /	Seguro Social	(E) (E)	
Empleado — — — — — — — — — — — — — — — — — — —	Tel ()	ATA	
Empleado Direction	Ciudad Estado	Codigo Postal	
2)			
Nombre de			
Aseguranza			
Numero de ID	Numero de Gr	upo	
Nombre de Responsable			
Nombre de Responsable/ Fecha de Nacimiento/ Empleado	/ Seguro Social		
Empleado		p=	
Empleado Direction	Ciudad Estado	Codigo Postal	
ENICACO DE EMEDOI	CNICIA		
EN CASO DE EMERGI	ENCIA		
Nombre	Relacion con Pa	aciente	
Direccion	Ciudad Est	tado Codigo Postal	
Tel ()	<u>(#</u> 5)		
Estoy de acuerdo en acept	tar la responsabilidad r	entistica nor los servicio	ns al
<u> </u>	_	-	
paciente y autoizar pagos dep	rate de cualquier tipo de	beneficio medico al Dr. Bie	asoe
Firma del Paciente o Responsable			
Eacha			
Fecha			