

Drs. Sabet & Andrews
31852 Coast Hwy., Suite 105
Laguna Beach, CA 92651

Welcome To Our Office

Patient Information

Last Name _____ First Name _____ Initial _____
Name You Go By _____ Age _____ Date of Birth ____ / ____ / ____
Street _____ City _____ State _____ Zip _____
Home Phone () _____ Cell Phone () _____
Social Security # _____ Driver's License # _____
Employer _____ Phone () _____ Ext. _____
Occupation _____ Business Phone () _____
Street _____ City _____ State _____ Zip _____
Marital Status: M S W D Spouse's Name _____

Referring Information

Who may we thank for referring you? _____
Family Doctor _____ Previous Podiatrist _____
What is your chief foot complaint? _____

Financially Responsible Party (If different from patient)

Last Name _____ First Name _____ Initial _____
Date of Birth _____ Age _____ Home Phone () _____
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License # _____
Employer _____ Phone () _____ Ext. _____
Street _____ City _____ State _____ Zip _____

Eligibility Waiver

I state that I am eligible for benefits under _____ health plan. If the above is not true, I (or the person responsible for me) will be responsible for all charges related to services provided to me. In addition I understand that any services which are denied or are not part of my benefit package are my responsibility.

Signature: _____ Date: _____ Email: _____

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Medical History

What is your foot problem?

When did problem begin? _____ Date (if an injury): _____

Describe any accident/event _____

First visit to a Doctor for this problem? Yes No

Describe any previous treatment or home remedies _____

Do you have or have you ever been treated for:

Diabetes Yes No

HIV Yes No

Heart Disease Yes No

High Blood Pressure Yes No

Poor Circulation Yes No

List other health problems: _____

Allergies to injection, oral or topical administration of:

Penicillin or other antibiotics? Yes No

Narcotics? (Codeine, Vicodin) Yes No

Local anesthetics? Yes No

Adhesive tape? Yes No

Latex? Yes No

Any other drug or medication? Yes No

Please List: _____

Please list your medications: _____

Are you slow to heal after cuts? Yes No

Any abnormal bruising or bleeding? Yes No

Height: _____ Weight: _____

How much are you on your feet at work?

20% 40% 60% 80% 100%

List any sports/activities: _____

Do you smoke? Yes No

Do you drink alcoholic beverages?

None Rarely Moderately Daily Quit

Please list previous medical or surgical problems: _____

Have you been treated for this problem before? _____

If female, are you pregnant? Yes No

Have you ever had foot surgery? Yes No When and by whom? _____

Have you had x-rays taken for this problem? Yes No When and by whom? _____

Name: _____

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

The *Health Insurance Portability & Accountability Act of 1996* (“HIPAA”) requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed.

We may use and disclose patient medical records only for the following purposes:

- Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)
- Health care operations:** conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.
- We may create and distribute non-identified health information by removing all references to individually identifiable information.
- We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
- Any other uses and disclosures may be made only with patient’s written authorization.
- We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.

Patients have the following rights with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Office Manager:

- The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient.
- The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization’s Privacy Practices and give my consent to use my protected health information under the conditions provided.

Patient or Guardian

Date

You have my permission to leave messages for me on my home phone, cell phone or email.

Patient or Guardian

Date