Welcome

Cedars Foot & Ankle Center

N. Hollywood • Inglewood

Patient Information

Date _____ Patient SS# _____

Patient Name_____

Address_____

_____

Sex: ☐ M ☐ F Age _____ Date of Birth _____

Marital Status:

☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Separated

Occupation _____

Employer _____

Employer Address_____

Employer Phone _____

Spouse's Name _____

Whom may we thank for referring you? _____

_____

Phone Numbers

Home _____ Work/Cell _____

In case of emergency, contact:

Name _____

Phone # _____

Insurance

Person responsible for account _____

SS# of responsible person _____

S.S. # _____ Date of Birth _____

Insurance Co. _____

Group # _____ ID # _____

PPO, HMO and Worker's Comp. Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with above company and assign to Dr. Soleymani, and/or to Cedars Foot & Ankle Center 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 hereby authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Medicare & Medi-Cal Authorization

I request that payment of authorized Medicare and/or Medi-Cal benefits be made either to me or on my behalf to Drs. Soleymani, Naraghi, and/or to Cedars Foot & Ankle Center for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Podiatric History

What is the chief complaint for which you came to be treated? (Include foot, ankle, leg, knee, thigh and hip complaints)

_____

_____

Have you been to a Podiatrist/Foot Doctor before?

☐ Yes ☐ No

If yes, please list:

Name: _____

Last Visit: _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Alcohol _____

Cigarette/Tobacco use_____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns & Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

Medical History

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

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Medicine	☐ Yes	☐ No	Eye Problem	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Sinus Problem	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Kidney Problem	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Wart	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Nervous/Psychiatric care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Circulatory Problem	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other: _____		
Ear Problem	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	_____		

Other Illnesses: _____

Surgeries you have had: _____

_____

Hospitalization other than for the surgeries listed: _____

_____

Your Primary Medical Doctor: _____ Date of last visit: _____

Immediate Family History

❑ Stroke	❑ Arthritis	❑ High Blood Pressure	❑ Other: _____
❑ Cancer	❑ Kidney Disease	❑ Flat Foot	
❑ Diabetes	❑ Osteoporosis	❑ Seizure	_____

Medications

Include all prescriptions, over-the-counter medications and vitamins

_____

_____

_____

_____

_____

Allergies

❑ **NO ALLERGIES**

❑ Adhesive/Tape
❑ Codeine
❑ Iodine
❑ Novocain
❑ Penicillin
❑ Seafood
❑ Sulfa
❑ Other _____

Consent for Procedures & Privacy Practices Acknowledgement

I certify that the above information is true and correct to the best of my knowledge. I authorize Drs. Soleymani, Naraghi or associates, assistants and/or other qualified medical personnel of their choice administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my podiatric medical condition. I acknowledge that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Signature: _____ Date: _____