Arash R. Hassid, DPM
Daniel L. Altchuler, DPM
Eileen Haworth, DC

SoCal Foot & Ankle Doctors

1260 15th St. Suite 707
Santa Monica, CA, 90404
Tel: (310) 451-8045
Fax: (310) 451-8139
www.Socalfootankledrs.com

Patient Information Form

(Please Print)

Date: ___/____/____

Patient Name: _____ Date of Birth:___/____/____ Age: ___
Last *First* *MI*

Sex: M F Other (please specify):_____

Home Address: _____City/State: _____ Zip: _____

May we leave a message?

Home Phone #: (____) ____-_____ Yes No

Work Phone #: (____) ____-_____ Yes No

Cell Phone #: (____) ____-_____ Yes No

E-mail: _____ 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 #:** (____) ____-_____

Who Referred You To us/How did you find us? _____

Current Problem

What specific problem(s) brings you to our office today **(please specify right, left or both)**?

_____

_____

_____

_____

When did your problem start? _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

Was this problem caused by an injury? □ Yes □ No *(describe)*

_____

_____

_____

If yes, was it a work-related injury? □ Yes □ No

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Patient Name: _____ DOB: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

_____
_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____
_____
_____
_____

SOCIAL HISTORY

MARITAL STATUS:

☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL:

☐ **NEVER** ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ 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 _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

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

DO OTHERS DEPEND UPON YOU FOR THEIR CARE?
☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

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Patient Name: _____ DOB: _____

Family History

☐ **None Known**

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 _____

Your Medical History

Allergies:

☐ **None Known**
☐ Medications _____
☐ Anesthesia _____ ☐ Foods _____
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other _____

Have you ever had any of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer (What kind?)	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or Type 2 (circle)	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Other Conditions:

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

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Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- **We are only contracted with St. John's HMO group and we are not contracted with any Medicare Advantage Plans or other HMO Groups.**

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check **(Please Make Checks Payable to SoCal Foot & Ankle Doctors).**

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days. Overdue accounts are subject to a **$15** fee. Accounts 90 days in arrears will be subject to collection by an external agency unless financial arrangements are made with our office

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay/coinsurance/deductible.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- There is a service fee of **$25.00** for all returned checks. Your insurance company does not cover this fee.

- Office Administrative fees: X-ray Copies **$15**/CD, Chart Copy **$25**+, Disability Forms **$50** each, New health/life insurance policy forms **$50** each, jury summons, travel cancellations, health club forms **$50** each.

- We understand that some appointments cannot be kept due to unforeseen circumstances. However, we ask for a 24-hour notice so that time can be rescheduled for another client. Our policy is to charge **$75.00** for an appointment that is cancelled with less than 24-hour notice.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____Date: _____

_____ Patient initials to indicate copy received.

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Your Rights Regarding Your Health Information

1. *Communications.* You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of you health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Santa Monica Podiatry Group*.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Santa Monica Podiatry Group*. You must provide us with a reason that supports your request for amendment.

5. You have the right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front office receptionist.

6. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

8. Any pictures taken from me at *Santa Monica Podiatry Group* will solely be used for purposes of electronic medical chart keeping and will not be shared with any marketing and/or advertising agency, unless requested by any federal or state governmental agency.

If you have any questions regarding this notice or our health information privacy policies, please contact *Santa Monica Podiatry Group*.

I hereby acknowledge that I have been presented with a copy of *Santa Monica Podiatry Group's* Notice of Privacy practices.

_____ _____
Signature of patient or patient representative Date

_____ _____
Printed name of patient/patient's representative Relationship to patient