ARTISAN
FOOT AND ANKLE
SPECIALISTS

Devon Glazer, DPM
Bahar Golshahi, DPM
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PATIENTS' INFORMATION

Date: ______/______/______

Legal Last Name: ______________________ Legal First Name: ____________________MI ___________

Address: __________________________________ City: _______________________ State: _____________

Zip Code: _______________

Home Phone: ______________________ Leave a message? Y/N

Cell Phone: ________________________ Leave a message? Y/N Text Message Reminders: Y/N

Occupation: _______________________ Primary Language: ________________

Work Phone: ___________________________________________

DOB: _____/______/_______ M / F (circle one) SS#: _______/________/______ (Please provide last 4 digits)

Relationship Status: Single/ Married/ Divorced/ Widowed/ Domestic Partnership

Email Address: ______________________________________________

Emergency Contact: _________________________________________

Relationship: ________________ Phone: ________________________

I give permission to speak or leave a message with __________________. This will be in effect until revoked in writing.

REFERRING PHYSICIAN/PRIMAY CARE PHYSICIAN: __________________/________________

Preferred Pharmacy & Location (cross streets):_____________________________________________

PRIMARY INSURANCE (PLEASE CIRCLE ALL THAT APPLY)

I have provided my cards at my initial appointment to be scanned into my chart. _______Initial

MEDICARE/ PPO/ WORK COMP/HMO/ SELF-PAY/ OTHER: ________________

Insurance Name: _______________________________

Insurance Phone: ___________________________________

Insured Subscriber's Name: _________________________________________________

DOB: __________/__________/__________

ID#: __________________ Group #: ________________________ Effective Date: ________________

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT NAMED ABOVE INCLUDING BUT NOT RESTRICTED TO DRUGS, MEDICINE, PERFORMANCE OF OPERATION AND CONDUCT OF LABORATORY, X-RAYS, OR OTHER STUDIES THAT MAY BE USED BY DR.GLAZER AND DR. NOSRATI, THEIR ASSISTANTS OR ANY OTHER QUALIFIED DESIGNANTE. I AGREE TO ARBITRATOR MEDIATION IN THE CASE OF DEBATE IN REGARDS TO TREAMENT. I CONSENT TO THE TAKING AND PUBLICATION OF ANY PHOTOGRAPHS DURING THE COURSE OF THIS TREAMENT FOR THE PURPOSE OF ADVANCING MEDICAL EDUCATION. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

SUBSCRIBER/INSURED SIGNATURE: _______________________________ DATE: _____________________

**PATIENT HEALTH HISTORY**

Your Health History is **IMPORTANT**. Please answer all questions thoroughly.

Name: ____________________________ Today's Date: _____________________

Height:_______ Weight:______ Shoe size:_______

**Chief Complaint**

Why are you seeing the doctor today? _______________________________________________________

Date of Injury: _________________ Date of Surgery: ___________________

Pain Level of Injury ( 0-10 where 0=none, 10=extreme): __________

Current problem is the result of a(n): Check all that apply Car Accident______ Work Accident_____ Other:________________

**Past Medical History**

**Medication**

| Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies:**_______________________________________________________________________________________

**Circle all that apply**

Diabetes High Blood Pressure Heart Disease Lung Disorders High Cholesterol Kidney Problems Prostate Problems Thyroid

Anemia Arthritis Gout Liver Disease Psychiatric Stroke TB Hepatitis Seizure Bleeding Disorders Polio Multiple Sclerosis Eating Disorder STD's AIDS/HIV Low Blood Pressure

Cancer Type & Current Status: ___________________________________________

Other (please describe): _________________________________________________

## Past Surgical History

**Surgeries/Hospitalizations:**

| Surgery | Year | Outcome/Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Have you ever had general anesthesia? No Yes

Have you ever had any problems with anesthesia? No Yes

Please Describe___________________________________________________________________________

Do you have sleep apnea? If yes are you using CPAP?___________________________________

## Review of Systems

Are you currently having or have you had problems with your:

**Circle/Describe all "Yes" Responses:**

| | | | | | |
|---|---|---|---|---|---|
| Eyes | No | Yes______________ | Ears,Nose,Throat | No | Yes________________ |
| Lungs, breathing | No | Yes______________ | Irregular Heart Beat | No | Yes________________ |
| Digestion | No | Yes______________ | Bowel Movement | No | Yes________________ |
| Bladder Problem | No | Yes______________ | Bleeding Problems | No | Yes________________ |
| Balance Problem | No | Yes______________ | Numbness/Tingling | No | Yes________________ |
| Blackout/Fainting | No | Yes______________ | Headaches | No | Yes________________ |
| Psych | No | Yes______________ | Fevers/Chills | No | Yes________________ |
| Chest Pain | No | Yes______________ | Skin Issues | No | Yes________________ |
| Back Pain | No | Yes______________ | | | |

Pregnancies No Yes Number of Pregnancies: _________ Complications?________________

**Activity Level**

How often do you exercise? What do you do for exercise?

Daily Weekly Monthly Rarely Never

**Social Habits**

Do you have a history of substance abuse?  No  Yes What? _____________________

Drink Alcohol?  No  Daily  1-2 x/week  1-2 x/month  1-2 x/year

Currently Smoking?  No Yes _______ Packs per day _____ for ______ years

Quit Smoking? _______ previously smoked ________ packs per day for _______ years.

Have you used other tobacco products?  No  Yes What? _____________________

Are you exposed to tobacco in your household?  No Yes

**Family History**

| | Age | Deceased/Alive | Medical Condition |
|---|---|---|---|
| **Father** | | | |
| **Mother** | | | |
| **Brother** | | | |
| | | | |
| **Sister** | | | |
| | | | |
| | | | |

**I certify that the above information is correct to the best of my knowledge, I will not hold my Doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Patient Signature: _____________________________ Date: ______________

Guardian Signature: ___________________________ Date: ______________

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**Late Appointment Cancellation**
**No -Show Policy for Doctor Appointments and Surgery**

**To All Artisan Foot and Ankle Patients:**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.  However, when you do not call to cancel an appointment in advance, it prevents an injured or emergent patient form getting in to a preferred appointment time. **"NO SHOW"** appointments increase healthcare delivery costs and may affect your future health plan. Due to the amount of recent no shows and late appointments cancellations we are now establishing a policy that if you do not show or do not cancel in a 24 hour period you will be charged a fee of $50.00. This policy will be in effect immediately.

I have read and understand the above statement.

X ____________________________________________________________
Patient signature
Date:

X_____________________________________________________________
Print name

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**Questions and Complaints**

If you want more information about our policy practices or has questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to you protected health information or in response to a request you made, you may complain to us using the contacted information below.

**Name of contact person:** Alyssa Hernandez **Telephone:** 949-272-0007 ext 7

**Email:** **www.office@artisanfeet.onmicrosoft.com**

You also may submit a written complaint to the *U.S Department of Health and Human Services.*

We will provide you with the address to file your complaint with the *U.S Department of Health and Human Services* upon request. We support your right to protect the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or the *U.S Department of Health and Human Services.*

X ____________________________________________________________
Patient signature
Date:

X____________________________________________________________
Print name