FOOT & ANKLE ASSOCIATES
14642 Newport Ave., Suite 450 • Tustin, CA 92780
Tel: (714) 669-4422 • Fax: (714) 669-4444

PATIENT INFORMATION

Date____________________

SS #____________________

Patient Name____________________
Last Name

____________________ ________
First Name Middle Initial

Address____________________

City____________________

State__________ Zip__________

Email____________________

Sex ☐M ☐F Age______ Birth date__________

☐ Married ☐ Single ☐Minor

Primary Care Physician ____________________

Patient's Employer/School ____________________

Employer/School Address ____________________

____

Employer/School Phone ____________________

Spouse's Name ____________________

Birth date ____________________

SS # ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

____

PHONE NUMBERS

Home (____) __________ Cell (____) __________

Best time and place to reach you ____________________

Pharmacy Name & Number ____________________

____

IN CASE OF EMERGENCY, CONTACT:

Name ____________________

Relationship to Patient____________________

Home Phone (____) ____________________

Cell Phone (____) ____________________

INSURANCE

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birth date __________ SS# __________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

____
Name of Insurance Company(ies)

and assign directly to Dr. ____________________
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 authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to

____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____
Signature of Beneficiary, Guardian or Personal Representative

____
Please print name of Beneficiary, Guardian or Personal Representative

__________ __________
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is your chief complaint? __________

____

____

Duration ____________________

Location (See diagram to right)

What makes it better or worse? __________

____

Past Treatments for this? __________

____

Quality (i.e. itchy,burning,stabbing) ______

____

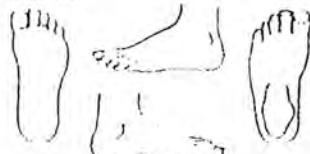
Severity ____________________

Timing (day,night,after walking) __________

____

Please use diagram to show location of your foot problems

Left Foot



Right Foot

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

Ankle Pain	☐ Yes	☐ No
Athletes Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Cramps or Numbness in feet or legs	☐ Yes	☐ No
Corns and Calluses	☐ 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

Height: ________ Weight: ________

MEDICAL HISTORY

Check (√) any of the following you have, or have had a problem with in the past:

☐ Anemia	☐ Eye problems	☐ Phlebitis
☐ Angina	☐ Fainting/Dizziness	☐ Psychiatric Disorders
☐ Arthritis	☐ Foot or Leg Cramps	☐ Respiratory Disorders
☐ Asthma	☐ Frequent Infection	☐ Rheumatic Fever
☐ Back Problems	☐ Gout	☐ Shortness of Breath
☐ Bleeding Disorders	☐ Headaches	☐ Stomach Ulcers
☐ Blood Clots (DVT)	☐ Heart Disease	☐ Stroke
☐ Cancer	☐ Hemophilia	☐ Swelling of the feet/ankles
☐ Chemical Dependency	☐ Hepatitis	☐ Tuberculosis
☐ Chest Pain	☐ High Blood Pressure	☐ Unexpected fever/ weight loss
☐ Circulatory Problems	☐ Kidney Disease	☐ Varicose Veins
☐ Diabetes	☐ Liver Disease	☐ Venereal Disease
☐ Ear Problems	☐ Neurological Disorders	☐ Other ____________
☐ Epilepsy	☐ Nose Problems	☐ None

Women Only: Are you pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No Oral Contraceptives? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Surgery	Year

HEALTH HABITS

Check (√) which one you use and how much.

☐ Alcohol ____________

☐ Tobacco ____________

☐ Street drugs ____________

☐ Caffeine ____________

☐ Other ____________

MEDICATIONS

Drug	Dosage

ALLERGIES

☐ None	☐ Anesthetics
☐ Adhesive Tape	☐ Iodine
☐ Anticoagulants	☐ Penicillin
☐ Aspirin	☐ Seafood
☐ Codeine	☐ Sulfa
☐ Latex	☐ Other________

FAMILY HISTORY

Is there a family history of any of the following?

☐ Heart Disease	☐ Arthritis	☐ Bleeding Disorder	☐ Circulation problems of the legs
☐ Neurological Disease	☐ Stroke	☐ Flatfeet	
☐ Bunions	☐ Hammertoes	☐ Diabetes	

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever has a change in health.

______________________________ ____________

Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ____________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

______________________________ ____________

Physician Signature — Date

OC Foot & Ankle Associates

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Dr. Anjala Kanda Dr. Sneh Mehtani

NEW HIPPA PRIVACY REGULATIONS

Federal law, the health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of Dr.Kanda and Dr.Mehtani will not reveal any personal information about you or a family member (i.e. name, address, social security number, as well as other health information) without permission. Your information will never be sold or listed for the purpose of advertisement, solicitation or fundraising.

It is however understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinion/care.
- Insurance: verifications, billing, paper and wire (including fax transmissions), insurance company follow up or interaction with billing services relating to patient care.
- Pursue collection of unpaid bills.
- Hospital workers, nurses, aids and medical records department
- Emergency officials, paramedics, fire personnel, emergency room, physicians, nurses or technicians.
- Personal religious designate
- Completion of disability forms.
- Computer and electronically stored information (i.e. related business vendor and services person).

I authorize the release of this necessary information.

X____

Patient/Parent signature Date