Pedram Kahen, DPM
Diplomate, American Board of Foot and Ankle Surgery

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _______________ _______________ ____ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

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

DO YOU CONSENT TO RECEIVING TEXT, E-MAIL AND VOICE MESSAGING: ☐ YES ☐ NO

EMERGENCY CONTACT: _________________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

PRIMARY CARE DOCTOR: ______________________________________ PHONE______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: ____

INSURED NAME: _______________________ DATE OF BIRTH ____________

EMPLOYER: __________________________________ OCCUPATION:_______________________________________

714 N. Avalon Blvd. Wilmington, CA 90744 (888) 535-3668 Fax: (888) 269-5439
511 E. Manchester Blvd. Inglewood, CA 90301 (888) 535-3668 Fax: (888) 269-5439

Patient Initial: ____

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

NAME DOSAGE

____
____
____

PLEASE LIST ALL PRIOR SURGERIES:
TYPE OF SURGERY DATE

____
____
____

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

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER ____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ________________________________
☐ ANESTHESIA ____________________ ☐ FOODS ______________________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ______________________
☐ NONE KNOWN

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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	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ______________________________

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 PODIATRIC PHYSICIAN

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
SIGNATURE

____
DATE

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _________________________________ Date of Birth: _______________

I have received this practices notice of privacy practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information.

The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required by law to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make to each of the following purposes: Treatment, payment and healthcare operations.
- Description of uses and disclosures that will be made only with a written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I made exercises these rights in the relation to:

    - The right complaint this practice, medical Board of California and to the secretary of human health services if I believe my privacy rights have been violated, and no retaliatory actions will be used against me in the event of such complaints
    - The right to request restrictions on certain uses and disclosures of my protected health information and at this practice is not required to agree to a requested restriction.
    - The right to receive confidential communication of protected health information.
    - 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 obtain a paper copy of the notice of privacy practices from this practice upon request

This practice reserves the right to change in terms of its notice of privacy practices and two making U. provisions effective for all protected health information that it maintains. I understand that I can obtain this practices / current notice of privacy practices upon request.

Patient's signature___________________________________ Today's date______________

Relationship the patient (if signed by patient's representative) _________________________

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Financial Policy

Patient Name: ___________________________________ Date of Birth: _______________

Thank you for choosing **Pedram Kahen, DPM / Legacy Foot and Ankle Center** as your health care provider. We are committed to your treatment being successful. The following is a statement of our **Financial Policy** that we ask you to read, agreed to & sign prior to any treatment.

1. Payment is due at the time services are rendered, including copayment, deductibles and previous balances. We do bill insurance plans as a courtesy, but it is not a guarantee of payment. The accepts catch, checks, visa, MasterCard, American Express, and Discover.
2. It is your responsibility to verify with insurance plan/carrier prior to each appointments group and individual doctor is a participating provider. Please verify if any services such as office visits, orthotics, braces, injections, x-rays, surgeries and procedures require preauthorization. Some plans require preauthorization or referrals from the patient's family physician.
3. Written or verbal authorizations from insurance plans or management groups are not guaranteed of payment. All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at the time of review. **Denied claims become the patient's responsibility.**
4. Statements are mailed after the insurance company has paid their portion. The count is then payable within 30 days. Overdue accounts are subject to $15 fee. Accounts 90 days past due are subject to collection by an external agency, unless financial agreements are made with our office.
5. All supplies and products are dispensed which are not billable insurance must be paid for at the time they are dispensed.
6. Parking: Is **FREE** behind our building in our parking lot. Street parking with parking meters are also available but it is patient's responsibility to pay the meter and to keep track of the meter time. Also avoid Street parking during Street cleaning hours. **Any parking fine is the patient's responsibility to pay.**
7. There is a $25 charge for any and all forms filled out by our office. Please allow 15 days for completion of forms.
8. If for any reason you are more than 15 minutes late, we may have to reschedule the appointment.

I HAVE READ THE ABOVE AGREEMENT AND AGREE THE TERMS AND CONDITIONS AS SET FORTH BY **PEDRAM KAHEN, DPM / LEGACY FOOT AND ANKLE CENTER.**

Patient's signature_____________________________________ Today's date______________

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