# Matt Ahmadi D.P.M., Inc.

26800 Crown Valley Parkway, Suite 320 • Mission Viejo, CA 92691 • Office (949) 276-8900 • Fax (949) 276-8901

## Welcome To Our Office

### Patient Information

Date: Home Phone #: ( ) Cell Phone #: ( )

Last Name: First Name: Middle Initial: Sex: ❒ M ❒ F

Address: City: State: Zip:

Social Security #: Driver's License #:

Date of Birth: / / Age: Marital Status:

Employer: Occupation:

Employer Address: City: State: Zip:

Work Phone #: ext: May we call you at work? ❒ Yes ❒ No Work Hours:

E-mail:

### Financially Responsible Party (If different from patient)

Home Phone #: ( ) Relationship to Patient:

Last Name: First Name: Middle Initial: Sex: ❒ M ❒ F

Address: City: State: Zip:

Social Security #: Driver's License #:

Date of Birth: / / Age: Marital Status:

Employer: Occupation:

Employer Address: City: State: Zip:

Work Phone #: ext: May we call you at work? ❒ Yes ❒ No Work Hours:

### In Case of an Emergency

Who should we notify? Relationship to Patient:

Phone #: ( ) Cell Phone #: ( )

*Whom may we thank for referring you?* _____

**Please read and sign below:** I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

Further there are no cancellation or refunds pertaining to custom molded orthotic devices under any condition. Durable medical equipment ex. Post operative shoes, boots, splints, braces and temporary orthotic devices are non-returnable and non-refundable once purchased or dispensed.. **It is our policy to collect all co-payments and deductibles at the time of service. You will be asked to provide us with a credit card to charge all amounts due when your insurance company has determined the additional portion of the bill due from you. We will send you a statement first.**

We feel it is important to note that **your insurance coverage is a contract between you and your insurance company, not this office.** We cannot take responsibility for large out of pocket costs, special claim forms, or delays and denials by your insurance company.

If you have any questions regarding your insurance coverage, please discuss it with your insurance company prior to your visit. They can help you determine the extend of your insurance coverage. This also applies if your insurance coverage should change in the future. Although, we can assist you in determining your benefits, this does not supplant the need for you to contact your insurance company directly to determine your benefits.

*It is the policy of this office to bill your insurance for reimbursements. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.*

I hereby give authorization for treatment and give full consent and understanding of the above office policies of Matt Ahmadi DPM INC. _____

**Signature Required** **Date**

## What is your foot/ankle problem?

When did the problem begin? Date:

Describe any accident/event:

Is this problem work related? ❒ Yes ❒ No

Is this your first visit to a Doctor for this problem? ❒ Yes ❒ No

Previous x-rays? ❒ Yes ❒ No If yes, Date:

Where are they now?

Describe any previous treatment or home remedies?

Height: Weigh: Shoe Size:

How much are you on your feet at work?

❒ 20% ❒ 40% ❒ 60% ❒ 80% ❒ 100%

List any sports/activities:

Do you smoke cigarettes? ❒ Yes ❒ No Packs/Day Years:

Did you ever smoke? ❒ Yes ❒ No Packs/Day Years:

Do you drink alcoholic beverages?

❒ None ❒ Rarely ❒ Moderately ❒ Daily ❒ Quit

## Have you been treated for?

| | | |
|---|---|---|
| ❒ Low back pain | ❒ Broken foot bone(s) | ❒ Flat Feet |
| ❒ Ankle Injury | ❒ Ingrown nails | ❒ Intoeng |
| ❒ Callouses | ❒ Neuroma | ❒ Knee Pain |
| ❒ Bunions | ❒ Heel Pain | ❒ Rash |
| ❒ Corns | ❒ Arch Pain | ❒ Hammertoes |
| ❒ Childhood foot problems | | |

## Do you have or have you ever been treated for?

| | | |
|---|---|---|
| ❒ Diabetes | ❒ Hepatitis | ❒ HIV |
| ❒ Anemia | ❒ Phlebitis | ❒ High Blood Pressure |
| ❒ Blood disease | ❒ Heart trouble | ❒ *Sleep Apnea |

| | |
|---|---|
| * Do you use a CPAP machine? | ❒ Yes ❒ No |
| Are you slow to heal after cuts? | ❒ Yes ❒ No |
| Any abnormal bruising or bleeding? | ❒ Yes ❒ No |
| Any pain in calves or buttocks when walking? | ❒ Yes ❒ No |
| Is the pain relieved by rest? | ❒ Yes ❒ No |
| Do your feet hurt at night? | ❒ Yes ❒ No |
| Currently taking any prescription medications? | ❒ Yes ❒ No |

List All Medications:

## Allergies to injection, oral or topical administration of:

| | |
|---|---|
| Penicillin or other antibiotics? | ❒ Yes ❒ No ❒ Don't Know |
| Narcotics? (Morphine, Codeine, Demerol) | ❒ Yes ❒ No ❒ Don't Know |
| Local anesthetics? | ❒ Yes ❒ No ❒ Don't Know |
| Pain remedies? | ❒ Yes ❒ No ❒ Don't Know |
| Adhesive tape? | ❒ Yes ❒ No ❒ Don't Know |
| Any other drug, medication or treatment? | ❒ Yes ❒ No ❒ Don't Know |

If yes, to any of the above, please explain:

| | |
|---|---|
| Have you had a serious illness? | ❒ Yes ❒ No |
| Have you been hospitalized or under lengthy medical care? | ❒ Yes ❒ No |
| Have you had any surgery? | ❒ Yes ❒ No |
| Do you have any implants? | ❒ Yes ❒ No |
| Orthopedic (e.g. hip, knee, etc.) | ❒ Yes ❒ No |
| Cardiac (e.g. valve, pacemaker, graft, etc.) | ❒ Yes ❒ No |
| Cosmetic (e.g. breast, facial, etc.) | ❒ Yes ❒ No |

If yes, to any of the above, please explain:

## Patient Physicians

Did your Family Physician or other Specialist refer you?

❒ Yes ❒ No

Family Physician:

Date last seen: Phone #: ( )

City: State: Zip:

Specialist Dr:

Specialty:

Date last seen: Phone #: ( )

City: State: Zip:

| | |
|---|---|
| Are you here for a consultation? | ❒ Yes ❒ No |
| Are you here for a surgical evaluation? | ❒ Yes ❒ No |
| Are you here for a 2nd opinion on surgery? | ❒ Yes ❒ No |
| Did you independently come for an opinion? | ❒ Yes ❒ No |

## Family History

Has a blood relative had:
(If "Yes", please indicate who on the line below)

| | | |
|---|---|---|
| High Blood Pressure? | ❒ Yes ❒ No | |
| Heart Trouble? | ❒ Yes ❒ No | |
| Diabetes? | ❒ Yes ❒ No | |
| Arthritis? | ❒ Yes ❒ No | |
| Stroke? | ❒ Yes ❒ No | |
| Foot Problems? | ❒ Yes ❒ No | |