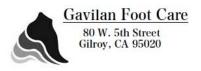


# Dr. Kaveh Akhbari, DPM, PC gavilanfootcare.com

Patient's Name,							
Last		First		Middle Int.	Husband/Wife Name		
Date of Birth	Sex	Age	_Marital Status	S□M□ D□ W□			
If minor, name of parent or guardian				Relationsh	ip to minor		
*Race	ce*Ethnicity			*Nationality			
(i.e White, Asian, Ai American, etc.) *Optional	frican-	(i.e Non-Hispa	nic, Latino, etc.)	(i.e American	, Mexican, British, etc.)		
Patient's Address		Home Phone #		CellPhone #			
City		State		Zip Code			
Patient e-mail address							
 Occupation- Patient (p	arent if minor)	Employer		Address	Work Phone #		
Occupation- Husband/	Wife	Employer		Address	Phone		
Emergency Contact			Phone				
By Whom were you ref	erred?		Address				
Who is your Physician?			Address				



### **INSURANCE WAIVER**

I, \_\_\_\_\_, Name of patient

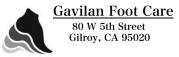
### UNDERSTAND THAT I AM ELIGIBLE FOR BENEFITS WITH

	AS OF					
Primary Insurance Carrier Effective date (if NO insurance, please write "None" on form)						
SUBSCRIBER NAME:						
SUBSCRIBER DATE OF BIRTH_						
SS#:	_					
GRP.#						
AS C	)F					
Secondary Insurance Carrier (if NONE, please write "None" on	Effective date form)					
SUBSCRIBER NAME:						
SS#:	_SUBSCRIBER DOB:					
GRP#:	-					
I UNDERSTAND THAT IN THE ON NON OR PARTIAL PAYMENT, I PAYMENT OF MY ACCOUNT.	CASE OF INELIGIBILITY, DENIAL, AM RESPONSIBLE FOR THE					

\_\_\_\_

Responsible Party Signature

DATE\_\_\_\_\_

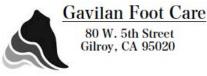


## Dr. Kaveh Akhbari, DPM

### Medical History

Patient Name:				Date: Health History				
What is the reason for your visit?				□ Arthritis (Type: □ Rheumatoid □ Osteo □ Degenerative)				
				$\Box$ Diabetes ( $\Box$ Type I DM $\Box$ Type II DM)				
				Cancer Type:				
				□ Neuropathy	Circulation Problems	□ Gout		
What is the date o	of your injury or o	onset of your symp	toms?	🗌 Fibromyalgia	Artificial Heart valve	🗆 Asthma		
				□ Hypertension	□ Congestive Heart Failure	□ Stroke		
Where is the prob	lem site?			□ Hypotension	Respiratory Problems	🗆 Epilepsy		
🗆 Left 🛛 Right 🖓 Foot 🖓 Ankle 🖓 Heel 🖓 Arch			Heart Problems	s 🗌 Kidney Dysfunction	□ Fainting			
□ Other:			🗌 Low Back Pain	Liver Disease	Hepatitis			
Describe your symptoms:			□ HIV/AIDS	□ HIV/AIDS □ Unexplained Weight Loss				
Pain Swelling Numbness Tingling Burning			Other:	□ Other:				
🗆 Dull 🛛 Sharp	) 🗌 Pain witl	h Activity 🛛 🛙	Pain at Rest					
□ Other:			Surgical Histo	Surgical History				
What previous treatments have you had?			Surgical Procedure	Surgical Procedure/Complications				
□ Orthotics	□ Medicatio	on 🗆 Physic	cal Therapy					
□ Injection	□ Surgery							
Other:								
Pain Assessme	ent							
Indicate pain level	on scale of 1-10,	, 10 being worst pa	in	Hospitalizatio	on	□ None		
1 2 3		6 7 8	9 10	Reason / Procedu	Date			
Current Medi	cation(s) Pleas	e include dosage	□ None					
		0						
				Social History				
				Smoking: Are you	a current smoker?			
				Current Smoker	· □ Non-Smoker			
				□ Former Smoker	cigarettes a day do you smoke?	<b>3</b>		
Allergies			□ None		$\Box$ 11-20 $\Box$ 21-30 $\Box$ 31 or m			
□ Latex	Penicillin	🗆 Sulfa		<u>Alcohol:</u> Did vou have a dri	nk containing alcohol in the pa	ast vear?		
□ Codeine	□ Aspirin			□ Yes	Did you have a drink containing alcohol in the past year? □ Yes			
□ Lidocaine						1 1 10		
	Adhesive/Tape 🗆 Iodine 🔅 Seafood		If Yes, how often d □ Monthly or less	If Yes, how often did you have a drink containing alcohol? ☐ Monthly or less				
				$\Box$ 2 -3 times a wee				

\_



Dr. Kaveh Akhbari, DPM

#### NOTICE AND ACKNOWLEDGEMENT

(Please INITIAL on the lines before each sentence)

I acknowledge that I have received and read a copy of the following documents (**in bold**) and by signature, I agree to:

- 1) \_\_\_\_\_ Authorize Gavilan Foot Care Center to make referrals on my behalf and share relevant clinical and demographic information as outlined in the **HIPAA Patient Consent Form and the Practice Privacy document.**
- 2) \_\_\_\_\_ Authorize Release of Medical Information to specified individuals provided by me, to Gavilan Foot Care Center.
- 3) \_\_\_\_\_ Authorize **Release of Information** regarding my medical treatment when requested by my insurance carrier and authorize **Assignment of Benefits**/payments directly to Gavilan Foot Care Center for the provision of surgical and medical benefits. (Insurance Waiver)
- 4) \_\_\_\_\_ The retrieval of my prescription history via the SureScripts clearinghouse and to the submission of electronic prescriptions to my preferred pharmacy
  - a. Your Preferred Pharmacy\_\_\_\_\_\_City\_\_\_\_\_
- 5) \_\_\_\_\_ I have received and reviewed the Lifetime Authorization regarding Medicare's coverage for Routine Foot Care
- 6) \_\_\_\_\_ Office hours are by appointments only. I understand that failure to notify our office within 24 hours or failure to show may result in a \$25 charge.
- 7) \_\_\_\_\_ PAYMENTS WITH INSURANCE: Copayments are due and payable at the time of service. The amount that your insurance carrier determines is your responsibility and payable within 30 days of notification by your carrier. After 30 days, a \$5.00 billing charge will be added to each statement sent. After 90 days a \$25.00 late fee in addition to the \$5.00 billing charge will be added to each statement
- 8) **Insurance**: Our office will submit insurance claims following treatment. Prior to your treatment, please establish eligibility with your insurance company and if prior authorization is required

X\_\_\_\_\_

Signature of Patient or Guardian

Date

Relationship to Patient, if signed by Representative