OC FOOT AND ANKLE INSTITUTE
Medicine & Surgery of the Foot & Ankle
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OC FOOT & ANKLE INSITITUTE

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: _____/______/______

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

HOME ADDRESS: ______________________________ CITY/STATE: ___________________ ZIP: __________

HOME PHONE #: (_____) _______-________

WORK PHONE #: (_____) _______-________

CELL PHONE#: (_____) _______-________

E-MAIL: _______________________________________

PRIMARY LANGUAGE SPOKEN: _______________________________________

SSN: ________________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP: __________ PHONE #: (____) ____-______
(NAME)

PRIMARY CARE DOCTOR: ___________________ WHO REFERRED YOU TO US? ___________________________

PHARMACY: ____ PHONE #: (____) ______-_______

INSURANCE INFORMATION

I HAVE INSURANCE: [ ] NAME OF INSURANCE: ____

I DO NOT HAVE INSURANCE: [ ]

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIPTIONS ONLY):

NAME DOSE HOW OFTEN DO YOU TAKE?

____
____

LIST ALL PRIOR SURGERIES OR HOSPITALIZATIONS:

TYPE DATE:

____
____

PATIENT NAME: ________________________________
DATE OF BIRTH: ____/____/______

SOCIAL HISTORY:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ OCCASIONAL ☐ DAILY

USE OF TOBACCO: ☐ CURRENT USE ☐ NO CURRENT USE

USE OF RECREATIONAL DRUGS: ☐ CURRENT USE ______________________ ☐ NO CURRENT USE

EMPLOYER: ____________________________________ OCCUPATION: ____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ OCCASIONAL ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____ SHOE SIZE: _______________

FAMILY HISTORY

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

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS ____
☐ ANESTHESIA ______________________________ ☐ FOODS ______________________________________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____________________________________

DO YOU HAVE THE FOLLOWING?

ACID REFLUX	Y	N	TUBERCULOSIS	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	DIABETES	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

CURRENT REASON FOR VISIT

WHAT SPECIFIC SYMPTOM BRINGS YOU TO OUR OFFICE TODAY?

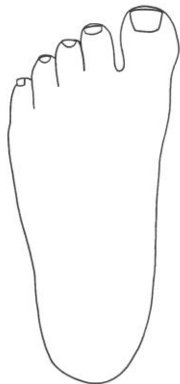
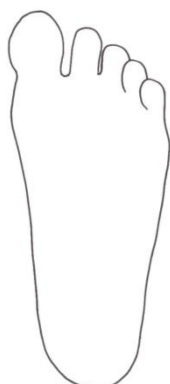
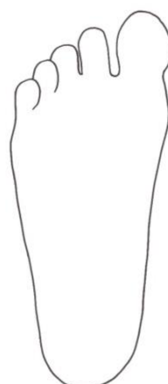
____

____

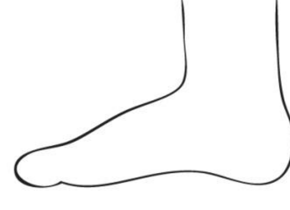
Patient Name: ________________________________
Date of Birth: ____/____/_____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot | **Right foot**

Top of Foot | Bottom of Foot | Bottom of Foot | Top of Foot



How long ago did this problem first start? ______________________ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually developed over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other ____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

What makes your pain or problem feel better? ____

What treatments have you had for this problem? ____

How has this problem affected your lifestyle or ability to work? ____________________________

Was this problem caused by an injury? ☐ Yes (describe) ______________________________ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

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 IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

______________________________ ______________________________

SIGNATURE DATE:

Office Policy & Procedures

We find it easier and less confusing if we clarify our billing, payment policy and office procedures at the beginning of your treatment program.

Prompt payment allows us to control costs. Outstanding accounts cost us both time and money; therefore all patients will be required to establish financial arrangements for payment of their account.

We will bill your insurance company as a courtesy, however, you are responsible for any co-payments, deductible or any services your insurance does not cover. It should be mentioned that your insurance coverage is an agreement between you and your insurer. If any problem occurs with your claim, you will be required to establish written financial arrangements with our office until your insurance problem is resolved. All patient bills are due upon receipt of statements.

If your insurance requires a written referral or prior authorization for treatment, surgery, or supplies, it is your responsibility to keep these current; even if we are the providers for your insurance.

Our office firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been trained and instructed to make every effort available to you, to clarify any misunderstanding you may have concerning your account balance. We strive to provide you with excellent service and avoid any disagreement over payment for professional services rendered.

I, the undersigned have read and fully understand and agree to the: “Office Policy & Procedures”. I have had all of my questions and/or concerns answered. By signing below, I authorize payment for medical services provided by: Amir Lebaschi, D.P.M. INC. I authorize the release of any medical information necessary to process this claim. Additionally, I authorize AMIR LEBASCHI, D.P.M. INC. to release information concerning my medical records to my primary care physician, in order to keep him/her apprised of my current health status.

Print Name: ______________________________ Date: ____________

Signature: ______________________________
PATIENT OR AUTHORIZED PERSON

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse of heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filling of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the within thirty days of a demand for a neutral arbitrator y either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to purse the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________ ____________________
Patient Signature **Date**