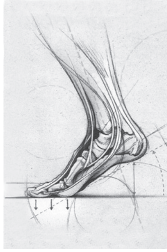


West Beverly Podiatry Group, Inc.

Diseases and Surgery of the Foot and Ankle

wbpgfoot.com

1417 West Beverly Blvd., Suite 104
Montebello, CA 90640
(323) 721-6026

931 Buena Vista St., Suite 305
Duarte, CA 91010
(626) 447-5122

Patient Information (Please Print)

Last Name: ______________________ MI: ______ First Name: ______________________

Social Security #: _____-____-______ Last Visit: ____/____/____ Date of Birth : ____/____/____ Sex: ☐ M ☐ F

Address: ______________________ City: ______________ State: _____ Zip: ________

Cell Phone: (______) __________ Home Phone: (______) __________ Work Phone: (______) __________

Referred By: Name: ______________________________ Phone: (______)__________

Primary Physician: Name: ______________________ Phone: (______)__________ Last Visit: ____/____/____

Pharmacy Name: ______________________________ **Pharmacy Phone**: (______)__________

Primary Language:______________________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Shoe Size: ______________ Weight: __________

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other: ______________________

EMERGENCY CONTACT INFORMATION

In Case of Emergency, Please Call: ______________________________ (______)__________

Relationship to the Patient: ______________________________

EMPLOYMENT INFORMATION

Employer Name: ______________________________ Occupation: ______________

Employer Address: ______________________ City: ______________ State: _____ Zip: ________

COMPREHENSIVE MEDICAL HISTORY

Allergies:

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine/Shellfish
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other Allergies:
- ☐ NONE

Current Medication List:

____
____
____
____
____
____
____
____

Please indicate if Mother or Father has had any of the following:

- ☐ Arthritis: MOM or DAD
- ☐ Birth Defects: MOM or DAD
- ☐ Cancer: MOM or DAD
- ☐ Diabetes: MOM or DAD
- ☐ Foot Problems: MOM or DAD
- ☐ High Blood Pressure: MOM or DAD
- ☐ Stroke MOM or DAD

Do you smoke now? ☐ No ☐ Yes Packs/day ________ Years ________
Did you ever smoke? ☐ No ☐ Yes Packs/day ________ Years ________
If you quit, when did you do so? ______________________________
Alcoholic beverages? (circle one): ○ None ○ Rarely ○ Moderately ○ Daily ○ Quit
Recreational Drugs? (circle one): ○ None ○ Rarely ○ Moderately ○ Daily ○ Quit

Do you have or have you ever been treated for:

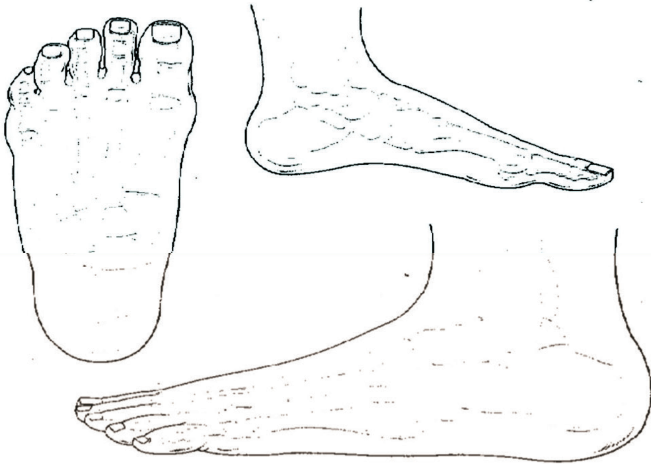
- ☐ Anemia
- ☐ Ankle sprain
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Arch pain
- ☐ Athlete's Foot
- ☐ Breathing Problems
- ☐ Broken Ankle
- ☐ Bunions
- ☐ Cramps in legs/feet
- ☐ Corns/Calluses
- ☐ Cancer
- ☐ Childhood foot problems
- ☐ Chronic diarrhea
- ☐ Diabetes
- ☐ Dark Urine
- ☐ Difficulty to stop bleeding
- ☐ Epilepsy
- ☐ Eves: Glaucoma/Manicular Deg
- ☐ Foot pain
- ☐ Foot numbness
- ☐ Fungal Nails
- ☐ Gout
- ☐ Gait (walking) problems
- ☐ Heart condition
- ☐ Hepatitis
- ☐ Heart attach
- ☐ Headaches
- ☐ Hearing/Ear disorder
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hammer/Mallet toes
- ☐ Heel pain
- ☐ High arch feet
- ☐ In-toeing
- ☐ Ingrown nails
- ☐ Keloid/Thick scar
- ☐ Kidney Disease
- ☐ Knee pain
- ☐ Leg or foot ulcers
- ☐ Liver Disease
- ☐ Lyme's Disease
- ☐ Lower back pain
- ☐ Lung Disease
- ☐ Neuroma
- ☐ Nerves Disorder
- ☐ Osteoporosis
- ☐ Polio
- ☐ Phlebitis
- ☐ Psychiatric Disorder
- ☐ Rash
- ☐ Rheumatic Fever
- ☐ Sexually transmitted disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Sciatica
- ☐ Substance Abuse
- ☐ Stomach Ulcer
- ☐ Tuberculosis
- ☐ Thyroid problem
- ☐ Unexplained weight loss
- ☐ Warts
- ☐ Other: ______________________________
- ☐ **None of the above**
- ☐ Any Metal or implants ______________________________

Previous Injuries	Previous Surgeries	Previous Hospitalizations

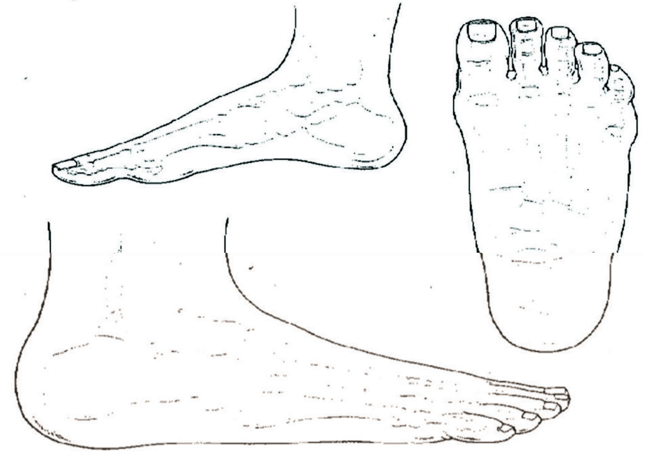
PATIENT'S CURRENT CHIEF COMPLAINTS

Describe 1 or 2 main problems in greater detail below and mark on the diagrams the areas where you have each problem using numbers 1 and 2 to identify them.

LEFT FOOT



RIGHT FOOT



Left foot

1.) Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain below It causes me difficulty:

☐ walking, ☐ wearing shoes and/or it...

____

____

____

Is problem work related? ☐ Yes ☐ No

Date of Injury: _____/_____/_____

Date of report to employer:: _____/_____/_____

2.) PAIN: Please indicate the severity of your pain or discomfort:

☐ None ☐ Light ☐ Moderate ☐ Strong ☐ Severe

My Pain/Discomfort is:

☐ Shooting Pain	☐ Aching Pain
☐ Throbbing Pain	☐ Tenderness
☐ Sharp Pain	☐ Dull Pain
☐ Burning Pain	☐ Tingling
☐ Itching	☐ Numbness

How long ago did the problem (pain) start?

_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:

○ while walking and/or: ○ while not walking

○ and/or: ______________________________

Previous medical treatment(s) or home remedies:

____

Right foot

1.) Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain below It causes me difficulty:

☐ walking, ☐ wearing shoes and/or it...

____

____

____

Is problem work related? ☐ Yes ☐ No

Date of Injury: _____/_____/_____

Date of report to employer:: _____/_____/_____

2.) PAIN: Please indicate the severity of your pain or discomfort:

☐ None ☐ Light ☐ Moderate ☐ Strong ☐ Severe

My Pain/Discomfort is:

☐ Shooting Pain	☐ Aching Pain
☐ Throbbing Pain	☐ Tenderness
☐ Sharp Pain	☐ Dull Pain
☐ Burning Pain	☐ Tingling
☐ Itching	☐ Numbness

How long ago did the problem (pain) start?

_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:

○ while walking and/or: ○ while not walking

○ and/or: ______________________________

Previous medical treatment(s) or home remedies:

____

New HIPAA 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 ***West Beverly Podiatry Group*** will not reveal to any person personal information about you or about 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 fund raising.

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 opinions/care
- Insurance: verifications, billing, paper and wire, (includes 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, Paramedic, fire personnel, emergency room physicians, nurses, or technicians
- Personal Religious designate
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

I authorize the release of this necessary information.

Patient's OR Guardian's Signature ______________________________ Date ____________

Authorization/Consent for Messages and Treatment

Contact Preferences:

Phone Number(s): ____________________

Okay to leave message with: ☐ patient only ☐ patient and/or spouse ☐ anyone answering phone

Patient's email address: ____________________

☐ **Yes, I authorize medical information to be left for the above contact preferences.**
☐ **NO, I do not authorize any medical information to be released.**

Patient's OR Guardian's Signature: ____________________

As patient or legal guardian, I hereby give permission to **West Beverly Podiatry Group** to administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition. I understand that any unpaid balance, not paid by my insurance company, becomes my responsibility and is due in full within 30 days of receipt of statement.

Patient's OR
Guardian's Signature: ____________________ Date: __________

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov