Patient Registration

Dr. Elle Farajian, D.P.M., FACFAS

Patient's Name _____ _____ _____
First *Last* *M.I.*

Address _____ **#** _____

_____ _____ _____
City ***State*** ***Zip code***

Phone: Home # _____ Cell # _____

Work # _____ Email _____@_____

SS# _____-_____-_____ **Date of Birth** ____/____/_____ **Gender** ___ Male ___ Female

Marital Status _____ **Your Occupation** _____

Primary Care Physician _____How did you hear about us?: _____
Name & Phone Number

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Minor's Responsible Party Name _____ _____ **Relationship** _____
First *Last* *M.I.*

Responsible party: Date of Birth ____/____/_____ **SS#** _____-_____-_____ **Gender** ___ Male ___ Female

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Primary Insurance Information Insurance Name _____

Policy Holder Name _____ DOB____/____/___

Insurance ID # _____Group # _____ Relationship to Holder _____

Secondary Insurance Information Insurance Name _____

Policy Holder Name _____ DOB____/____/___

Insurance ID # _____Group # _____ Relationship to Holder _____

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Preferred Pharmacy: _____
Pharmacy Name, Address & Phone Number

Emergency Contact _____ **Phone** _____**Relationship**_____

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I understand and acknowledge that I am personally responsible for the services rendered at this facility. Family Foot and Ankle will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

X _____ **Date** _____
Patient Signature or Guardian for the Minor Patient

17822 Beach Blvd., Suite 437
Huntington Beach, CA 92647
(714) 842-7277

MEDICAL QUESTIONNAIRE

PATIENT'S NAME _____
First M.I. Last

REASON FOR TODAY'S VISIT: _____ **FIRST DATE OF ONSET**: _____

DID THIS INJURY OCCUR AT WORK? ☐ Yes ☐ No

If yes, please describe how the injury occurred: _____

REFERING DOCTOR: **PRIMARY CARE DOCTOR**:

PAST MEDICAL HISTORY (Please √ if you have any of these in the past)

☐ Anemia	☐ Fracture History, please specify: _____	☐ Osteoporosis
☐ Arthritis		☐ Peripheral Vascular Disease/Poor Circulation
☐ Auto-immune Disease	☐ Fungal Infections	☐ Psoriasis
☐ Bleeding Disorders	☐ Gout	☐ Rheumatic
☐ Breathing problems/Lung Disorders	☐ Heart Disease	☐ Sciatica/Back Problems
☐ Cancer, please specify: _____	☐ High Blood Pressure	☐ Seizure Disorder
	☐ High Cholesterol	☐ Skin Cancer
☐ Cellulitis	☐ Gastrointestinal Reflux/Ulcers/Bleed	☐ Stroke
☐ Congestive Heart Failure	☐ Kidney Disease/Dialysis	☐ Thyroid Problems
☐ Deep Vein Thrombosis	☐ Liver Disease	☐ Varicose Veins
☐ Diabetes: ☐ Diet ☐ Oral ☐ Insulin	☐ Neuropathy	☐ Warts
☐ Other:		

CURRENT MEDICATIONS ☐ None ☐ I take the following prescription or over the counter medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES

☐ No known allergies
☐ I have the following allergies: ☐ Penicillin ☐ Shellfish ☐ Sulfa ☐ Codeine ☐ Iodine ☐ Aspirin/NSAIDs
☐ Adhesive/tape ☐ Cortisone ☐ Local anesthetics ☐ Other, please specify: _____

SURGICAL HISTORY/HOSPITALIZATIONS

☐ None
☐ I have had the following surgeries or hospitalizations in the past:

_____ Year: _____ _____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____ _____ Year: _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes, everyday (5-7 days /week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse:
☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem.
Do you exercise regularly? ☐ Yes, I do the following regular exercise: _____
☐ No, I do not exercise regularly.

_____ _____
Patient/Parent/Guardian **Date**

FINANCIAL POLICY

Dr. Elle Farajian, FACFAS

Thank you for choosing Family Foot & Ankle for your foot care. Our office strives to give five-star care for all of our patients and their families. Please read the following financial policy carefully and sign prior to seeing the doctor.

INSURANCE: Knowing your insurance eligibility and benefits is the patient's responsibility, but our staff is available for help when needed. As a courtesy to our patients, verifiable and assignable insurance will be billed by our office, and we will allow 60 days for your insurance company to pay. Please be aware that the balance for physician services is ultimately the patient's responsibility.

COPAYMENTS AND DEDUCTIBLES: ***All co-pays and/or deductibles are due at the time service is rendered.*** Once your insurance responds to the claim, if there is a balance due we will send out a statement to your address.

PAYMENTS: Cash, checks, debit and credit cards are accepted. There's a $25 fee for returned checks.

FORMS: Disability forms are assessed a $50 fee, payable in advance.

ORTHOTICS: Custom orthotics require a $100-$200 deposit, with the remainder due at time of pick up. We can check your insurance coverage as a courtesy, but that does not always guarantee payment from your insurance company, and the balance is patient responsibility.

DELINQUENT ACCOUNTS: Accounts that are 60 days overdue are in default and are subject to collections procedures and the added costs of collection.

I have read the financial policy and agree to its terms:

Patient's Name:_____ **Signature**:_____

Minor's Responsible Party's Name:_____ Signature:_____

Relationship to Patient:_____ **Date**: ____/_____/_____

HEALTH INFORMATION PRIVACY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment form third-party payors.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

You have informed me of your Notice of Privacy Practices containing a more complete description of the users. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at the time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Date: ____/____/_____

Relationship to Patient: _____

AUTHORIZATION TO RELEASE INFORMATION TO:

1)_____

2)_____