



**LOS ANGELES  
INSTITUTE OF  
FOOT & ANKLE  
SURGERY, INC.**

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NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PHARMACY: \_\_\_\_\_

PHARMACY PHONE NUMBER: \_\_\_\_\_

**ALLERGIES AND MEDICATIONS**

**ALLERGIES:**

MEDICATION _____	TYPE OF REACTION _____
MEDICATION _____	TYPE OF REACTION _____
MEDICATION _____	TYPE OF REACTION _____
OTHER SUBSTANCES _____	TYPE OF REACTION _____
OTHER SUBSTANCES _____	TYPE OF REACTION _____
OTHER SUBSTANCES _____	TYPE OF REACTION _____

**MEDICATIONS:**

MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____
MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____
MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____
MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____
MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____
MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____
MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____
MEDICATION _____	DOSAGE _____	STARTED _____	D/C _____

**www.newankle.com**

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Main Phone (818) 848-5588 • Main Fax (818) 848-5509  
 201 South Buena Vista Street • Suite 305 • Burbank, CA 91505  
 18350 Roscoe Boulevard • Suite 200 • Northridge, CA 91324  
 23911 Calgrove Boulevard • Santa Clarita, CA 91321  
 1808 Verdugo Boulevard • Suite 116 • Glendale, CA 91208



PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

WHO REFERRED YOU TO US? \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

CONTRACT #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

CONTRACT #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

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PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

HISTORY OF PRESENT ILLNESS (FOR PHYSICIAN USE): \_\_\_\_\_

\_\_\_\_\_

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLIES):

DIABETES (HOW MANY YEARS) \_\_\_\_\_ INSULIN-CONTROLLED (HOW MANY YEARS?) \_\_\_\_\_

ASTHMA/BRONCHITIS                      HIGH BLOOD PRESSURE                      HEART ATTACK/ ANGINA

ARTHRITIS                                      HIGH CHOLESTEROL                                      STOMACH ULCERS

GOUT    BLEEDING PROBLEMS                                      THYROID DISEASE

STROKE    HEPATITIS/LIVER PROBLEMS                                      SEIZURES

OTHER \_\_\_\_\_

ARE YOU CURRENTLY RECEIVING MEDICAL CARE? NAME OF DOCTOR \_\_\_\_\_

PAST SURGICAL HISTORY (PLEASE LIST ALL PRIOR SURGERIES):

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INJURIES/ ACCIDENTS/ BROKEN BONES: \_\_\_\_\_

SOCIAL HISTORY:

MARITAL STATUS:  SINGLE  MARRIED  PARTNERED  SEPARATED  DIVORCED  WIDOWED

USE OF ALCOHOL:  NEVER  NO LONGER USE  OCCASIONAL  MODERATE  DAILY

USE OF TOBACCO:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_  SMOKE \_\_\_\_ PACKS/DAY FOR \_\_\_\_ YEARS

USE OF RECREATIONAL DRUGS:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_ TYPE \_\_\_\_\_

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

FAMILY HISTORY:

DO YOU HAVE A FAMILY HISTORY OF:

DIABETES: TYPE 1 OR TYPE 2  CANCER  HEART DISEASE  HIGH BLOOD PRESSURE  STROKE

CORONARY ARTERY DISEASE  THYROID DISEASE  RHEUMATOID ARTHRITIS

OTHER: \_\_\_\_\_

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PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEW OF SYSTEMS HAVE YOU EXPERIENCED (PLEASE CIRCLE)

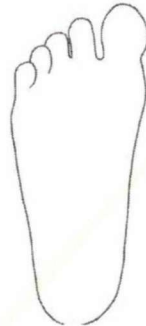
HEADACHES	DIZZINESS	WEIGHT GAIN/LOSS	DIFFICULTY BREATHING
CHEST PAIN	COUGHING	POOR CIRCULATION	GALLSTONES
PALPITATIONS	HEARTBURN	PAINFUL URINATION	SEIZURES
VOMITING	DIARRHEA	VISION PROBLEMS	DEPRESSION
WEAK MUSCLES	PARALYSIS	UPSET STOMACH	BLADDER INFECTION
JOINT PAIN	KIDNEY PROBLEMS	CHANGES IN URINARY FREQUENCY OR URGENCY	



TOP OF FOOT



BOTTOM OF FOOT



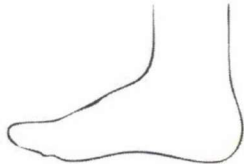
BOTTOM OF FOOT



TOP OF FOOT



INSIDE OF FOOT



OUTSIDE OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

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HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS/ WEEKS / MONTHS/ YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP 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)

0 1 2 3 4 5 6 7 8 9 10

NO PAIN

WORST PAIN POSSIBLE

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PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:

STAYED THE SAME     BECAME WORSE     IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?

WALKING     RUNNING     STANDING     DAILY ACTIVITIES     RESTING  
 DRESS SHOES     HIGH HEELS     FLAT SHOES     ANY CLOSED TOE SHOE  
 OTHER \_\_\_\_\_

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

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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

\_\_\_\_\_  
SIGNATURE OF DOCTOR

\_\_\_\_\_  
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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# **LOS ANGELES INSTITUTE OF FOOT AND ANKLE SURGERY**

TO OUR PATIENT: \_\_\_\_\_

RE: "**YOUR INSURANCE COVERAGE**"

If you have a managed care plan such as HMO, PPO, EPO, POS and MEDICARE plan you can be seen as an "out of network" patient. However, in many cases, you may need to meet a deductible, and reimbursement may be at a lower percentage, depending on the quality of your Insurance Carrier. To ease the financial burden courtesy discounts are frequently provided.

You may wish to contact your insurance company for additional information regarding benefits.

Your signature will indicate that you understand and agree with the above.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

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TO OUR PATIENT: \_\_\_\_\_

RE: "**DURABLE MEDICAL EQUIPMENT**"

Please be aware our office has purchased Durable Medical Equipment to provide to our patients.

There is an uncertainty and occasional low reimbursement from Medicare and all other insurance carriers. In light of this fact, you will be billed for any unpaid balance following payment by your insurance carrier.

The fee charged represents cost of the equipment plus a 10-20% handling fee.

Your signature will indicate that you understand and agree with the above.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

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I hereby authorize \_\_\_\_\_ to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

**Patient name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Persons/organizations to receive the information:** \_\_\_\_\_

**The specific information to be released/disclosed is specified below:**

**Complete Medical Record**  
**Or specify one or more of the following:**

<input type="checkbox"/> Operative Reports	<input type="checkbox"/> X-rays
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Billing and Claim Records
<input type="checkbox"/> Laboratory	<input type="checkbox"/> (Other - specify) _____

This information is to be used/disclosed for the following purposes(s) only: \_\_\_\_\_

(no purpose needs to be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on \_\_\_\_\_ (state date or event).

**SPECIFIC AUTHORIZATION**

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

Yes  No \_\_\_\_\_ Initials

\_\_\_\_\_  
**Signature of patient or patient's representative**  
(Form MUST be completed before signing.)

\_\_\_\_\_  
**Date**

**Printed name of patient's representative (if applicable):** \_\_\_\_\_  
**Relationship to the patient (if applicable):** \_\_\_\_\_

**\*YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**

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