Bobby Pourziaee DPM, Inc.

PATIENT DEMOGRAPHICS

Date of Birth:_____ SSN:_____

Full Name:_____Gender: ☐M ☐F ☐_____
First Middle Initial Last

Address:_____
Street Address Unit / Suite

_____
City State Zip / Postal Code

Phone Number: _____ _____
Mobile Home

Marital Status: ☐Married ☐Single ☐Other Email:_____

Emergency Contact:_____Number:_____

Employer Name/Occupation:_____

Preferred Pharmacy Name and Location:_____

Primary Physician:_____Number:_____

INSURANCE

Primary Insurance:_____

ID#:_____Group:_____

Insurance Address: _____Guarantor's D.O.B.:_____

Secondary Insurance:_____

ID#:_____Group:_____

Insurance Address: _____Guarantor's D.O.B.:_____

MEDICAL HISTORY

Are you currently under your physicians' care? If yes, for what reason?
Name and Phone number of Doctor:_____

_____

Have you had previous treatment by a podiatrist? If yes, for what reason?

_____

_____

Do you have any allergies? Please include prescription medication, over the counter medicines, food adhesives, seasonal, etc...

_____

_____

What is your allergic reaction to these?

_____

_____

Please list all medications you are currently taking or provide us with a printed list.:

_____

_____

Please list any herbal or dietary supplements you are currently taking.

_____

_____

Are you pregnant? If so, what is your expected due date? _____

Please list all surgeries you have had in the past:

_____

_____

Have you ever been hospitalized? If so, please list approx dates and reasons.

_____

_____

Is there anything else you would like to mention about your visit today?

_____

PATIENT INFORMATION

Height: _____ Weight: _____ Shoe Size: _____

My chief foot complaint is:_____

How long has the condition existed?_____

Symptoms:_____

Which Foot: □Right □Left □Both
Type of Pain *Check all that apply*: □Dull □Achy □Throbbing □Sharp □Burning □Shooting
How does the pain start?: □Slow □Sudden □Traumatic

Area of Pain in the foot:_____

Since your pain began, has it gotten: □Better □Worse □Stayed the same

What aggravates your condition? □Walking □Running □Standing □Wearing Shoes

What have you tried to help with the pain? *Check all that apply*

□New shoes □Anti-Inflammatory □Decrease in activities □Ice □Arch Supports
□Orthotics □Stretches □Other_____

Have you ever smoked / vaped tobacco? □Yes □No
What year did you start _____ quit _____

Do you currently smoke / vape tobacco? □Yes □No

How long have you been smoking / vaping: ___ Days ___ Weeks ___ Years
How much do you smoke?: Pack / Cartridge ___ Day ___ Week

Do you drink alcohol? □Yes □No

If No when did you, Start _____ Quit _____
How many days/drinks per week: Days_____ Avg # of Drinks _____

Do you take recreational Drugs including cannabis?□Yes □No

If so, what type? _____

PATIENT HISTORY QUESTIONNAIRE

Please check the box if you or have had any of the following

PERSONAL		FAMILY
☐	Diabetes - Type I or Type II	☐
☐	High Blood Pressure (HBP)	☐
☐	Cancer - Type_____	☐
☐	Bleed Easily	☐
☐	Alcoholism	☐
☐	Arthritis:	☐
	☐ RA	
	☐ Fibromyalgia	
	☐ Gout	
	☐ Type_____	
☐	Epilepsy	☐
☐	HIV Positive	☐
☐	Stroke	☐
☐	Anemia	☐
☐	Artificial Joints/Valves Type:_____	☐
☐	Asthma	☐
☐	Back Problems	☐
☐	Chemical Dependency	☐
☐	Chest Pain	☐
☐	Circulatory Problems	☐
☐	Depression	☐
☐	Eating Disorder	☐
☐	Heart Disease	☐
☐	Hemophilia	☐
☐	Hepatitis Type_____	☐
☐	Kidney Problems	☐
☐	Leg Cramps	☐
☐	Liver Disease	☐
☐	Lung / Respiratory	☐
☐	Menopause	☐
☐	Mental Illness	☐
☐	Psychiatric issues	☐
☐	Phlebitis/Clots	☐
☐	Psoriasis	☐
☐	Rheumatic Fever	☐
☐	Thyroid Problems	☐
☐	Tuberculosis	☐
☐	Stomach Ulcers	☐
☐	Venereal Disease	☐
☐	Weight Change	☐

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I hereby consent to and authorize all treatment that may be necessary to and advisable by Dr. Bobby Pourziaee and his staff. I understand that no guarantee or assurance has been made as to the results that may be obtained. I understand that charges will be made for the office visit and other procedures such as x-rays, laboratory examinations, etc... and hereby agree that I am financially responsible for any charges not covered by my health care plan. I hereby authorize the Doctor to release all information necessary to secure the payments of health care benefits.

Patient Name:_____

Patient Signature:_____

Date:_____

Parent/Guardian Name & Signature (if applicable):

_____

Date:_____

Palm Springs Podiatry
707 E Tahquitz Canyon Way, G9
Palm Springs, CA., 92262
(707) 507-4000

Pahrump Podiatry
2080 E Calvada Blvd
Pahrump, NV., 89048
(775) 751-5200

Rodeo Drive Podiatry
415 N Crescent Dr, Ste 340
Beverly Hills, CA 90210
(310) 441-0088

CANCELATION POLICY

A $35.00 Cancellation fee will be applied to appointments not canceled within 24 hours. This fee pertains to ALL appointments.

Patient Name:_____

Patient Signature:_____

Date:_____

Parent/Guardian Name & Signature (if applicable):

_____

Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE.

I acknowledge that I was provided a copy of the Notice of Privacy Practices by Dr. Bobby Pourziaee, D.P.M. and that I have read, or had the opportunity to read if I so choose and understand the Notice.

Patient Name:_____

Patient Signature:_____

Date:_____

Parent/Guardian Name & Signature (if applicable):

_____

Date:_____

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PREVENTATIVE CARE REQUIREMENTS

I, Authorize the medical staff of Dr. Bobby Pourziaee to perform a toe nail clipping biopsy of two toes **once a year** as a preventative care measure to check for possible fungal infections that may or may not be visible by visual inspection.

I further authorize the office of Dr. Bobby Pourziaee to perform a Lower Arterial Study (93923 cpt) known as a Doppler on both feet. '*The Doppler is a preventative measure to show blocked or reduced blood flow through narrowing in the major arteries. It also can reveal blood clots in leg veins (deep vein thrombosis, or DVT) that could break loose and block blood flow to the lungs (pulmonary embolism).* I agree and understand this is not only part of a new patient evaluation but will be performed **semi-annually** as a preventive care diagnostic test, or as medically necessary.

I also understand these tests will be billed to my medical insurance carrier.

Patient Name:_____

Patient Signature:_____

Date:_____

Parent/Guardian Name & Signature (if applicable):

_____

Date:_____

PATIENT AUTHORIZATION FOR PHOTO OR VIDEO

I, Authorize Palm Springs Podiatry to photograph or video record my foot, ankle or leg region to use in my HIPPA protected medical records for progress tracking, and/or the circumstances surrounding my medical care and treatment that I have been receiving and/or will receive in the future.

Patient Name:_____

Patient Signature:_____

Date:_____

Parent/Guardian Name & Signature (if applicable):

_____

Date:_____

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