PATIENT MEDICAL HISTORY

Name ______________________________ Age ________

Welcome to our office. Thank you for your attention to this form.

Are you allergic to any medication(s)? NO ☐ YES ☐ what medication(s)?

____

____

What Medication(s) are you taking now? ______________________________

____

Do you have now, or have you ever had, any of the following : (Check Yes or No)

YES	NO		YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Anemia	☐	☐	Asthma or Bronchitis
☐	☐	High blood pressure	☐	☐	Stomach or intestinal problems (Ulcers, Colitis)	☐	☐	Immune diffidiency diseases
☐	☐	Kidney problems (Nephritis)	☐	☐	Liver problems (Hepatitis)	☐	☐	Chronic infections (Throat, Bladder)
☐	☐	Heart disease (Stroke, Heart attack)	☐	☐	Mental disorders	☐	☐	Cancer
☐	☐	Gout	☐	☐	Polio	☐	☐	Childhood diseases
☐	☐	Rheumatoid arthritis	☐	☐	Nerve / Neurological disorders (Paralysis, M.S., Epilepsy)	☐	☐	Skin problems (dermatitis, Psoriasis)
☐	☐	Osteo arthritis	☐	☐	Pneumonia	☐	☐	Vascular / circulatory problems (Leg cramps, Varicose veins, Hardening of arteries)

Describe any of the above conditions you checked "YES" ______________________________

____

Have you had any surgeries in the past? (List type & date of each surgery) ______________________________

____

Detail any additional information you think may be helpful ______________________________

____

Any family history of? Cancer ☐ ____________ Heart Disease ☐ ____________

Who? (ie. Mother, Son, etc.) Diabetes ☐ ____________ High blood pressure ☐ ____________

Do you smoke? ☐ YES ______ ☐ NO ______ Drink Alcohol? ☐ YES ______ ☐ NO

Are you pregnant? ☐ YES ______ ☐ NO ______

Do you take antibiotics before surgery or dental work? ☐ YES ____ ☐ NO ____

Thank you for taking the time to complete this questionnaire.

____
Patient's Signature

Revised 10/02

Dr. Mathew Safapour, DPM

Dr. Matthew Safapour, D.P.M.

PATIENT PERSONAL INFORMATION:

Last Name ______________________ Middle ______ First Name ______________________

Home Address ____

City ____________________ State ______________ Zip ______________

Cell # (   ) ______________ Home # (   ) ______________ Work # (   ) ______________

Email ____________________ Social Security # ____________________ Sex ______

Drivers License # ____________________ Date of Birth ______________ Marital Status ______

Emergency Contact Name ____________________ Tel. # (   ) ______________ Relation ______

How did you find out about us? TV ____________ Radio ____________ Yellow Pages ____________

(Patient Referred By) Doctor ____________ Patient ____________ Other ____________

(Optional): Race ____________ Ethnicity ____________ Preferred Language ____________

INSURANCE INFORMATION:

Name of Insurance Company ______________________ Tel # (   ) ______________

Insurance ID # ______________________ Group # ______________

RESPONSIBLE PARTY INFORMATION : (Insured Information)

Name ______________________ Relationship to Patient ______________

Address ______________________ Tel. # (   ) ______________

Date of Birth ______________ Social Security # ______________

If Patient is a Minor, Name of Responsible Parent ______________________

I will be paying today by: _____ cash _____ check _____ other

TREATMENT AGREEMENT

With regards to podiatric care and service provide or to be provided, IT IS AGREED that: The ATTENDING PODIATRIST will provide podiatric care and services to the patient, to the best of his skill and knowledge, which podiatric care in the light of circumstance is possible and practical. The PATIENT will cooperate fully with the ATTENDING PODIATRIST by obtaining such medications as are prescribed, by following the instructions of the ATTENDING PODIATRIST, by adhering to such treatment regimen or course of action as may be set forth, and by paying all fees and charges in full as billed or as provided by prior special arrangements IT IS AGREED that: Because of differences in human constitution and response, it is in no way possible to warrant the outcome of such podiatric care and service. In the interest of good patient-doctor relationships, it is desirable to establish a good credit policy. An effective policy enables the doctor and patient to avoid misunderstandings.

I authorize the release of any podiatric information necessary to process claims for podiatric services and request payment made directly to the ATTENDING PODIATRIST and/or DR. MATTHEW SAFAPOUR, DPM. I understand that I am financially responsible for all charges not covered by my insurance benefits.

Patient Signature ______________________________ Date ______________

If the patient is a minor or incompetent, the parent or guardian should sign here, and in addition the minor or incompetent patient should sign above, if possible.

Parent or Guardian Signature ______________________________ Date ______________

Advance Directives- The Patient's Right to Decide

ACKNOWLEDGEMENT

Physician: Dr. Matthew Safapour DPM **Telephone: (818) 986-9898**

Address: 7325 Medical Center Dr. Suite# 307

West Hills, CA 91307

Patient's Name: ______________________ **DOB:** ________________

Address: ______________________ **Telephone:** ________________

____

____

Advance Directives-The Patient's Right to Decide

This acknowledgment that the physician or one of his/her staff members has provided me information concerning Advanced Directives.

1- I am age 18 or older. (Circle One) Yes No

2- I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.

3- I am aware that Advanced Directives may be any one of the following:

(a) A durable Power of Attorney for Health Care.
(b) The Declaration in the A natural Death Act-Ex. A Living Will
(c) I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

Patient's Signature: ______________________ **Date:** ________________

This document will become part of my medical record.

MRN:____________

Standard Authorization of Use and Disclosure of Protected Health Information

Information pertaining to Patient Name: ______________________________

Date of Birth: ____________________

Information may be disclosed or released by: Dr. Matthew Safapour, DPM, Staff & Employees. If specified, only the staff or employee named here may release or disclose information: ______________________________

Specify what may be released, i.e: all written and verbal information

____

Information may be disclosed or released to:

______________________________ Name ____________________ Relationship

______________________________ Name ____________________ Relationship

This authorization will expire in one year from the date signed, unless you specify a date less than one year from the date signed or unless terminated by the patient or patient's authorized representative. Specify expiration date if less than one year: ____________
The patient may revoke or terminate this authorization by submitting a written revocation to Dr. Matthew Safapour, DPM
Potential for Redisclosure:
Information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulation.

______________________________ Patient Signature

____________________ Signature of Patient Representative (if applicable)

______________________________ Date

____________________ Relationship