Robert Anavian, D.P.M
23456 Hawthorne Blvd.
Suite 270
Torrance, CA 90505
(310) 375-1417

PATIENT INFORMATION

Date: _____

Social Security #: _____

Patient Last Name: _____

First Name: _____ MI: _____

Address: _____

City:_____ State: ____ Zip: _____

E-mail: _____

Sex: □ M □ F Age: _____ Birthdate: _____

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered

Patient Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: (____) _____

Spouse's Name: _____

Birthdate: _____ SS#:_____

Spouse's Employer:_____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home Phone: (____) _____

Cell Phone: (____) _____

Best time and place to call: _____

In Case of Emergency, Contact

Name: _____

Relationship: _____

Home Phone: (____) _____

Cell Phone: (____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Pt. covered by additional Insurance: □ Yes □ No

Subscriber's Name: _____

Birthdate: _____ SS#:_____

Relationship to Patient:_____

Insurance Co.: _____

Group #: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with:

_____
Name of Insurance Company(ies)
and assign directly to Dr. Robert Anavian, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made on my behalf to Dr. Robert Anavian, DPM for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? □ Yes □ No
If yes, Please list.

Name: _____

Last Visit: _____

Is there any personal or family history of diabetes?
□ Yes □ No Explain:

_____

Cigarette/Tobacco use: _____

Years Smoked: _____

Your Occupation: _____

Athletic Activities you participate in (please list and indicate frequency):

_____

_____

_____

Please indicate which foot problems you now have of have had in the past.

□ Ankle Pain
□ Athlete's foot
□ Bunions
□ Corns and Calluses
□ Numbness in feet, legs
□ Flat Feet
□ Foot or Leg Cramps
□ Heel Pain
□ Ingrown Nails
□ Plantar Warts
□ Swelling of Ankles or Feet
□ Tired Feet

MEDICAL HISTORY

Please check any condition you have currently or in the past:

AIDS/HIV	□ Yes □ No	Ear Problems	□Yes □No	Radiation treatment	□Yes □No
Anesthetic Allergies	□ Yes □ No	Epilepsy	□Yes □No	Rash	□Yes □No
Medicine Allergies	□ Yes □ No	Eye Problems	□Yes □No	Respiratory Disease	□Yes □No
Anemia	□ Yes □ No	Fainting	□Yes □No	Rheumatic Fever	□Yes □No
Angina	□ Yes □ No	Foot or Leg Cramps	□Yes □No	Shortness of breath	□Yes □No
Arthritis	□ Yes □ No	Gout	□Yes □No	Sinus Problems	□Yes □No
Artificial Heart Valves	□ Yes □ No	Headaches	□Yes □No	Special Diet	□Yes □No
Artificial Joints	□ Yes □ No	Heart Disease	□Yes □No	Stroke	□Yes □No
Asthma	□ Yes □ No	Hemophilia	□Yes □No	Swelling in Ankles	□Yes □No
Back Problems	□ Yes □ No	Hepatitis or Jaundice	□Yes □No	Swollen Neck Glands	□Yes □No
Bleeding Disorders	□ Yes □ No	High Blood Pressure	□Yes □No	Tired Feet	□Yes □No
Cancer	□ Yes □ No	Kidney Problems	□Yes □No	Tuberculosis	□Yes □No
Chemical Dependency	□ Yes □ No	Liver Disease	□Yes □No	Ulcers	□Yes □No
Chest Pain	□ Yes □ No	Low Blood Pressure	□Yes □No	Varicose Veins	□Yes □No
Chronic Diarrhea	□ Yes □ No	Neuropathy	□Yes □No	Venereal Disease	□Yes □No
Circulatory Problems	□ Yes □ No	Phlebitis	□Yes □No	Weight loss, unexplained	□Yes □No
Diabetes	□ Yes □ No	Psychiatric Care	□Yes □No		

Surgeries you have had: _____

_____

_____

Hospitalizations other than for the surgeries listed: _____

_____

_____

Family Physician: _____ Last visit date: _____

Are you now, or have you been under any other doctor's care for any reason in the past two years? □ Yes □ No

If yes, please explain: _____

_____

_____

MEDICATIONS

Include prescriptions, over the counter medications and vitamins: _____

_____

_____

Pharmacy Name: _____ Pharmacy Phone: (____) _____

Do you take oral contraceptives? □ Yes □ No

ALLERGIES

□ Adhesive Tape □ Anticoagulant Therapy □ Aspirin □ Codeine □ Demerol □ Iodine

□ Local Anesthetics □ Novocain □ Penicillin □ Seafoods □ Sulfa

Please list any other Allergies you may have: _____

TREATMENT CONSENT

I hereby consent and give permission to Robert Anavian, DPM (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient