PREFERRED NAME: _____

LOCAL PHARMACY (please be specific with location): _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ (NARROW/REGULAR/WIDE/XTRA WIDE)

WHAT SPECIFIC FOOT PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

_____

_____

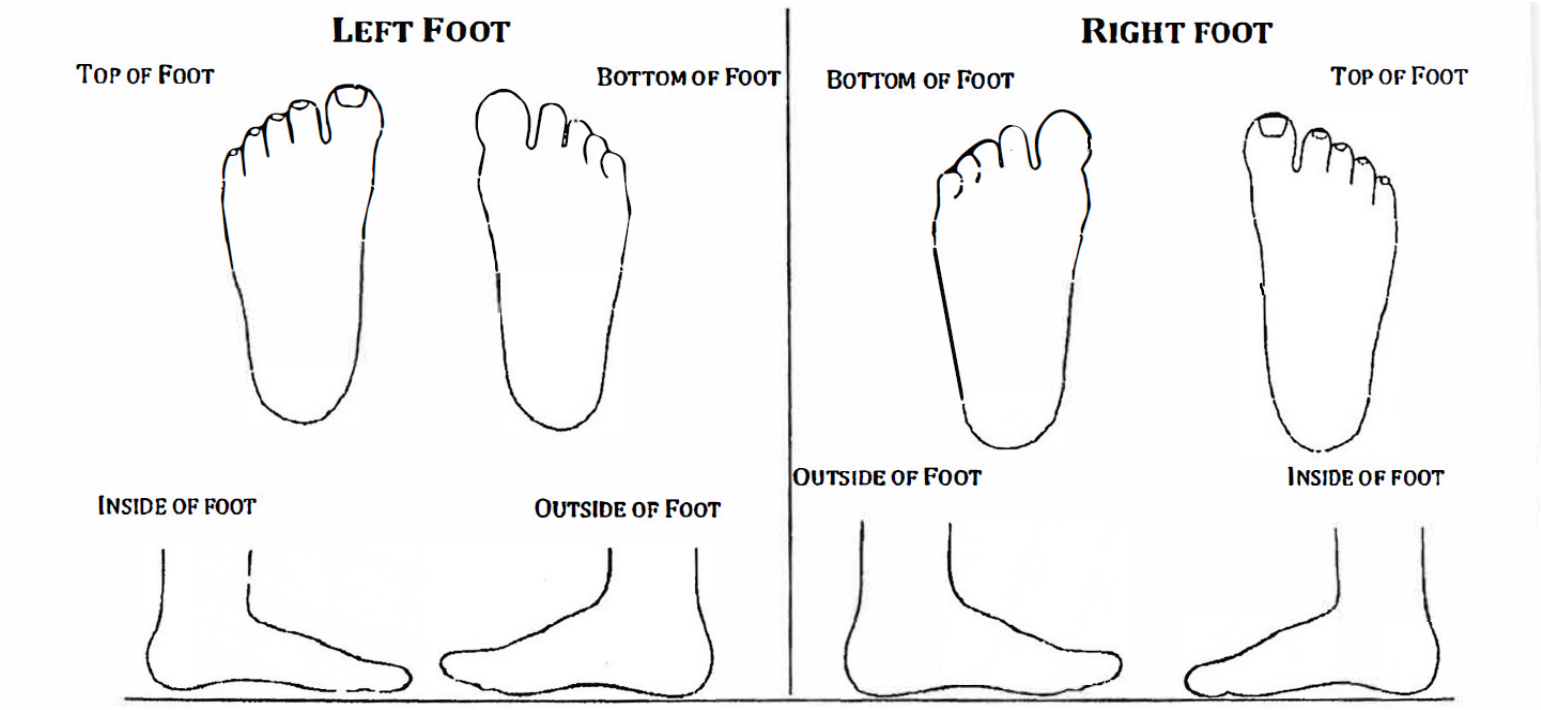
DO YOUR NAILS OR CALLUSES HURT? ☐ NO ☐YES (IF YES, PLEASE MARK TOE(S) ON IMAGES BELOW)

DO YOU USE BLOOD THINNERS LIKE COUMADIN, ELIQUIS, PLAVIX, ETC? ☐YES:_____ ☐NO

IF YES, WHICH DOCTOR PRESCRIBES THIS MEDICATION AND WHEN WERE YOU LAST SEEN: _____

DO YOU HAVE POOR BLOOD FLOW, COLD FEET, CRAMPING OR PAINFUL LEGS WHEN WALKING? ☐YES ☐ NO

WHERE IS YOUR TOENAIL/FOOT PAIN LOCATED? *PLEASE MARK ON THE IMAGES BELOW*



WHEN DID THIS PROBLEM START? _____ DAYS/WEEKS/MONTHS/YEARS

THIS PROBLEM: ☐ DEVELOPED ALL OF A SUDDEN ☐GRADUALLY DEVELOPED OVER TIME

☐CAUSED BY AN INJURY (IF SO, PLEASE DESCRIBE): _____

DESCRIBE THE PAIN: ☐NO PAIN ☐SHARP ☐STABBING ☐DULL ☐ACHING ☐BURNING ☐RADIATING ☐ITCHING ☐OTHER: _____ RATE YOUR PAIN (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

OVER TIME HAS THIS PROBLEM: ☐STAYED THE SAME ☐GETTING WORSE ☐IMPROVED

WHAT MAKES YOUR PROBLEM WORSE? ☐WALKING ☐STANDING ☐DAILY ACTIVITIES ☐RESTING ☐DRESS SHOES ☐HIGH HEELS ☐FLAT SHOES ☐ANY CLOSED TOE/TIGHT SHOE ☐RUNNING/HIKING ☐OTHER _____

WHAT MAKES THE PROBLEM BETTER: _____

WHAT TREATMENTS HAVE YOU TRIED: ☐REST ☐ICE ☐ MASSAGE ☐MEDICATION _____ ☐OTHER_____

WHO ELSE HAVE YOU SEEN FOR THIS PROBLEM: _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK: _____

MEDICAL HISTORY ***(PLEASE PROVIDE A COPY OF MEDICATION LIST OR OTHER PRE-FILLED FORMS)***

ILLNESSES PRIOR SURGERIES DATE

_____ _____

_____ _____

_____ _____

MEDICATIONS (INCLUDING PRESCRIBED, OVER THE COUNTER, HERBAL SUPPLEMENTS) ☐***COPY MY MED LIST***

MEDICATION NAME DOSE FREQUENCY PRESCRIBER REASON

_____

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING (IF NOT LISTED ABOVE):

☐DIABETES ☐HEART DISEASE ☐CANCER (TYPE) _____ ☐PACEMAKER ☐AFIB ☐OPEN HEART SURGERY
☐BLOOD CLOT/DVT ☐PVD ☐LEG ULCER ☐PHLEBITIS ☐ANEMIA ☐BLEEDING OR CLOTTING DISORDER
☐ASTHMA ☐BRONCHITIS ☐COPD ☐VALLEY FEVER ☐VISION LOSS ☐HEARING LOSS ☐HEADACHES
☐MIGRAINES ☐HEPATITIS ☐HIV ☐GOUT ☐RHEMATOID ARTHRITIS ☐OSTEOARTHRITIS ☐PSORIASIS
☐LYME DISEASE ☐ANXIETY / DEPRESSION ☐MEMORY LOSS ☐PSYCHIATRIC CONDITION (TYPE)_____
FAMILY HISTORY ☐DIABETES TYPE 1 OR 2 ☐CANCER ☐HEART DISEASE ☐STROKE ☐GOUT ☐OTHER_____

ALLERGIES ☐NONE KNOWN
☐PENICILLIN ☐SULFA ☐KEFLEX ☐CODEINE ☐MORPHINE ☐ASPIRIN ☐NSAIDS ☐ OTHER _____
☐ANESTHESIA REACTION _____ ☐FOOD ALLERGY_____
☐TAPE ☐LATEX ☐SHELLFISH ☐IODINE ☐OTHER _____

SOCIAL HISTORY MARITAL STATUS ☐SINGLE ☐MARRIED ☐PARTNERED ☐SEPARATED ☐DIVORCED ☐WIDOWED
ALCOHOL USE: ☐NEVER ☐NO LONGER ☐RARE ☐OCCASIONAL / SOCIAL ☐MODERATE ☐HEAVY
TOBACCO / VAPING: ☐NEVER ☐QUIT – WHEN? _____ ☐OCCASIONAL ☐DAILY _____ PACKS PER DAY
RECREATIONAL DRUGS: TYPE _____ ☐RARE ☐OCCASIONAL ☐DAILY
DO OTHERS DEPEND ON YOU FOR THEIR CARE: _____ CHILDREN (AGES)_____ ☐ELDERLY OR DISABLED FAMILY MEMBER
EXERCISE: ☐NEVER ☐YES BUT NOT CURRENTLY DUE TO INJURY ☐RARE ☐OCCASIONAL ☐WEEKLY ☐DAILY
TYPES OF EXERCISE/SPORTS: _____
EMPLOYER: _____ **OCCUPATION**: _____
HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

ANYTHING ELSE YOU WOULD LIKE US TO KNOW : _____
_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS, INCLUDING MEDICATIONS.

_____ _____
PRINT NAME OF PATIENT (OR PARENT OR GUARDIAN) SIGNATURE

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

The Agoura – Los Robles Podiatry Centers Welcomes You to Our Office

Darren Payne, Stephen Benson, Michael Zapf

Our office has been providing foot and ankle care for children & adults since 1982

Name (First, Middle Initial, Last)	Gender	Date of Birth	Age

Street Address	City	State	Zip	Email Address

Home Telephone Number	Cellphone Number

In the event our office needs to get ahold of you to relay diagnostic, lab or imaging results, please share which method we can leave confidential messages (if applicable): ☐Home Phone ☐Cell Phone ☐Email	☐I do not wish to have messages left containing health information anywhere

Race	Ethnicity	Marital Status S M D W	Primary Care Physician

How did you hear about our office? ☐Dr. _____ ☐ Friend/Family _____

☐Yelp ☐ NextDoor ☐Insurance Website ☐Internet Search ☐Other _____

Employer Name	Occupation	Work Telephone Number

Emergency Contact: Name, Relation, Phone Number

I authorize my medical information to be shared with the following individual: ☐I do not authorize the release to anyone

Name	Relationship	Telephone Number

Responsible Party ☐Same as above Name Relationship Telephone Number

Address (if different than above)

Insurance Information Primary Insurance Carrier Secondary Insurance Carrier

Are you the subscriber? ☐Yes ☐No Subscriber name and DOB (if you are the dependent): _____

By signing this I understand that payment for office visits or any procedures are expected when services are rendered unless other arrangements have been made in advance. I recognize that professional services are rendered and charged to me and not to my insurance company. I know and understand that I am responsible for any non-covered services as well as copayments and deductibles. I understand that proof of eligibility, coverage and non-covered services and various exclusions frequently cannot be determined until my carrier processes the claim. I know that billing insurance companies is a courtesy to me and that this podiatry office cannot accept the responsibility for collecting, negotiating or settling a disputed claim. I understand that filing of insurance claims does not guarantee payment by my carrier. **If my insurance company does not reimburse the office within 90 days of providing services, I agree to pay for the services myself** and, in turn, collect the reimbursement from my insurance company. While the office tries to comply with the requirements of my insurance companies, it is ultimately my responsibility to be aware of the limits and qualifications of my own policy, including the requirements for second opinions, pre authorizations assistant surgeon and orthotic coverage. I agree to pay for any treatment I receive that my insurance company will not pay for. I understand that an interest charge of 1.5% per month will be charged on all outstanding accounts and that an administrative charge of $30 will be added to the account if it should ever be turned over to a collection agency. I understand that I will be notified by regular mail at least 30 days before my account is ever turned over to an agency. I agree to keep the office informed of address changes. If arrangements are made for the office to bill an insurance company for services, I hereby assign all medical and surgical benefits to which I am entitled to the doctors. I authorize the physicians at the Agoura - Los Robles Podiatry centers to share information in order to provide my optimum care. Finally, by my signature I acknowledge that I have been advised of the HIPAA privacy rule which gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). **Please ask front office for a copy of our Privacy Practices if you wish**.

_____ _____

DATE SIGNATURE OF PATIENT OR RESPONSIBLE PARTY