Gavilan Foot Care
80 W. 5th Street
Gilroy, CA 95020

Dr. Kaveh Akhbari, DPM, PC
gavilanfootcare.com

Patient's Name,_____
Last First Middle Int. Husband/Wife Name

Date of Birth_____ Sex_____ Age_____ Marital Status S☐ M☐ D☐ W☐

_____ _____
If minor, name of parent or guardian **Relationship to minor**

*Race_____ _____*Ethnicity_____*Nationality_____
(i.e White, Asian, African-American, etc.) (i.e Non-Hispanic, Latino, etc.) (i.e American, Mexican, British, etc.)
*Optional

Home Cell
Patient's Address _____ Phone #_____Phone #_____

City _____ State _____Zip Code_____

Patient e-mail address:_____

_____
Occupation- Patient (parent if minor) Employer Address Work Phone #

_____
Occupation- Husband/Wife Employer Address Phone

Emergency Contact _____ Phone _____

By Whom were you referred? _____Address_____

Who is your Physician? _____ Address _____

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INSURANCE WAIVER

I, _____,
Name of patient

UNDERSTAND THAT I AM ELIGIBLE FOR BENEFITS WITH

_____ AS OF _____.
Primary Insurance Carrier Effective date
(**if NO insurance, please write "None" on form**)

SUBSCRIBER NAME:_____

SUBSCRIBER DATE OF BIRTH_____

SS#:_____

GRP.#_____

_____ AS OF _____.
Secondary Insurance Carrier Effective date
(if NONE, please write "None" on form)

SUBSCRIBER NAME: _____

SS#: _____ SUBSCRIBER DOB: _____

GRP#: _____

I UNDERSTAND THAT IN THE CASE OF INELIGIBILITY, DENIAL, NON OR PARTIAL PAYMENT, I AM RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.

_____ DATE_____
Responsible Party Signature

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Medical History

Patient Name: Date:

What is the reason for your visit?

What is the date of your injury or onset of your symptoms?

Where is the problem site?

☐ Left ☐ Right ☐ Foot ☐ Ankle ☐ Heel ☐ Arch

☐ Other:

Describe your symptoms:

☐ Pain ☐ Swelling ☐ Numbness ☐ Tingling ☐ Burning

☐ Dull ☐ Sharp ☐ Pain with Activity ☐ Pain at Rest

☐No

☐ Other:

What previous treatments have you had? ☐ *None*

☐ Orthotics ☐ Medication ☐ Physical Therapy

☐ Injection ☐ Surgery

☐ Other:

Pain Assessment

Indicate pain level on scale of 1-10, 10 being worst pain

1 2 3 4 5 6 7 8 9 10

Current Medication(s) *Please include dosage* ☐ *None*

Allergies ☐ *None*

☐ Latex ☐ Penicillin ☐ Sulfa

☐ Codeine ☐ Aspirin ☐ Anti-Inflammatories

☐ Lidocaine ☐ Novocain ☐ Local Anesthetic

☐ Adhesive/Tape ☐ Iodine ☐ Seafood

☐ Other:

Health History

☐ Arthritis (Type: ☐ Rheumatoid ☐ Osteo ☐ Degenerative)

☐ Diabetes (☐ Type I DM ☐ Type II DM)

☐ Cancer Type:

☐ Neuropathy ☐ Circulation Problems ☐ Gout

☐ Fibromyalgia ☐ Artificial Heart valve ☐ Asthma

☐ Hypertension ☐ Congestive Heart Failure ☐ Stroke

☐ Hypotension ☐ Respiratory Problems ☐ Epilepsy

☐ Heart Problems ☐ Kidney Dysfunction ☐ Fainting

☐ Low Back Pain ☐ Liver Disease ☐ Hepatitis

☐ HIV/AIDS ☐ Unexplained Weight Loss ☐ Obesity

☐ Other:

Surgical History ☐ *None*

Surgical Procedure/Complications Date

Hospitalization ☐ *None*

Reason / Procedure Date

Social History

Smoking: Are you a current smoker?

☐ Current Smoker ☐ Non-Smoker

☐ Former Smoker

If Yes, How many cigarettes a day do you smoke?

5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

Alcohol:

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

If Yes, how often did you have a drink containing alcohol?

☐ Monthly or less ☐ 2 -4 times a month

☐ 2 -3 times a week ☐ Daily

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NOTICE AND ACKNOWLEDGEMENT

(Please **INITIAL** on the lines before each sentence)
I acknowledge that I have received and read a copy of the following documents (**in bold**) and by signature, I agree to:

1) _____ Authorize Gavilan Foot Care Center to make referrals on my behalf and share relevant clinical and demographic information as outlined in the **HIPAA Patient Consent Form and the Practice Privacy document.**

2) _____ Authorize Release of Medical Information to specified individuals provided by me, to Gavilan Foot Care Center.

3) _____ Authorize **Release of Information** regarding my medical treatment when requested by my insurance carrier and authorize **Assignment of Benefits**/payments directly to Gavilan Foot Care Center for the provision of surgical and medical benefits. (Insurance Waiver)

4) _____ The retrieval of my prescription history via the SureScripts clearinghouse and to the submission of electronic prescriptions to my preferred pharmacy

   a. Your Preferred Pharmacy_____City_____

5) _____ I have received and reviewed the **Lifetime Authorization** regarding Medicare's coverage for Routine Foot Care

6) _____ Office hours are by appointments only. I understand that failure to notify our office within 24 hours or failure to show may result in a $25 charge.

7) _____ **PAYMENTS WITH INSURANCE**: Copayments are due and payable at the time of service. The amount that your insurance carrier determines is your responsibility and payable within 30 days of notification by your carrier. After 30 days, a **$5.00 billing charge** will be added to each statement sent. After 90 days a **$25.00 late fee in addition to the $5.00 billing charge** will be added to each statement

8) **Insurance**: Our office will submit insurance claims following treatment. Prior to your treatment, please establish eligibility with your insurance company and if prior authorization is required

X_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient, if signed by Representative