FOOT & ANKLE SPECIALTY GROUP

David J. Soomekh, DPM

Board Certified, American Board of Foot and Ankle Surgery
Fellow, American College of Foot and Ankle Surgeons

PH: 310.651.2366
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450 North Roxbury Dr.
Suite 200
Beverly Hills, CA 90210

FootAnkleSpecialtyGroup.com

Patient Registration

Patient Information

First Name	Middle Initial	Last Name

Sex M F	Date of Birth	Social Security Number	Marital Status

Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Preferred method of contact
□ Home Phone Call □ Cell Phone Call □ Cell Phone Text Message □ Email Message □ Other: _____

Primary Care Physician	Primary Care Physician Phone

Referred By	Referring Physician Phone

Pharmacy Name	Pharmacy Address	Pharmacy Phone

Meaningful Use Information

In compliance with Meaningful Use Objective (OBJ-304C); by the US government, it is required to capture race, ethnicity, and language information.

Race
□ American Indian / Alaskan Native □ Asian □ Native Hawaiian / Pacific Islander □ Black / African American □ White / Caucasian □ Hispanic
□ Other: _____ □ Refuse to report

Ethnicity
□ Hispanic / Latino □ Non - Hispanic / Latino □ Refuse to Report / Answer

Preferred language
□ English □ Spanish □ Russian □ Indian □ Other: _____

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relationship to Patient

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Billing and Insurance

Insurance Company	Insured Name	Insured Date of Birth	Relationship to Insured

Insured Address	City	State	Zip

Secondary Insurance Name *(if applicable)*	Insured Name	Insured Date of Birth

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Authorization for Use and Disclosure of Protected Health Information

I hereby authorize David J. Soomekh, DPM to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit re-disclosure by the person or entity receiving my PHI. I voluntarily agree to this authorization, and I understand that my health care will not be affected if I do not sign this form.
I hereby authorize use of my PHI for the purpose of diagnosing, treating, consulting, and referral.
I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims.
I acknowledge that I have read, understand, and have been offered a copy of the full HIPPA policy.

By my signature, I acknowledge that I have read and understand the Authorization for Use and Disclosure of Protected Health Information.

Patient or Guardian Signature: _____

Assignment of Benefits

I hereby authorize payments to be made directly to David J. Soomekh, D.P.M. for surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for the charges not covered by this Authorization. I further agree, in the event of Non-Payment, to bear the cost of reasonable legal fees should this be required. A photocopy of this Assignment shall be considered as effective and valid as the original.

By my signature, I acknowledge that I have read, understand and have been offered a copy of the Assignment of Benefits.

Patient or Guardian Signature: _____

Consent for Treatment

The information I provided is true to the best of my knowledge. I hereby give permission to the physician or his assistant(s) to initiate the diagnosis and treatment of my condition with examination, imaging studies, and/or photographs as deemed medically relevant and necessary. I also authorize the release of any previous medical records by fax, mail, electronic mail, or phone to either another treating physician or hospital as needed.

By my signature, I acknowledge that I have read and understand the Consent for Treatment.

Patient Name (please print): _____

Patient's Guardian (if applicable, print): _____

Patient or Guardian Signature: _____

Date: _____

David J. Soomekh, DPM

Medical History

FOOT & ANKLE SPECIALTY GROUP

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 ☐ Ankle ☐ Foot ☐ Heel ☐ Toes

☐ Other: _____

Describe your symptoms:

☐ Pain ☐ Swelling ☐ Numbness ☐ Tingling ☐ Burning

☐ Pain with Activity ☐ Pain at Rest

☐ Other: _____

What previous treatments have you had?

☐ 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*

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

Surgical Procedure/Complications	Date

Hospitalization

Reason / Procedure	Date

Family History

Father: ☐ Alive ☐ Deceased ☐ Unknown
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer: _____

Mother: ☐ Alive ☐ Deceased ☐ Unknown
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer: _____

Siblings:
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer: _____

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David J. Soomekh, DPM

Medical History

FOOT & ANKLE SPECIALTY GROUP

Patient Name: _____ Date: _____

Social History

Smoking

☐ Current Smoker ☐ Former Smoker ☐ Nonsmoker

↓

How often do you smoke cigarettes?

☐ Everyday ☐ Some days, but not everyday

How many cigarettes a day do you smoke?

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

How soon after you wake up do you smoke?

☐ Within 5 minutes ☐ 6-30 minutes

☐ 31-60 minutes ☐ after 60 minutes

Are you interested in quitting?

☐ Ready to quit ☐ Thinking about quitting ☐ Not ready

Alcohol

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

☐ Yes ☐No

↓

How often did you have a drink containing alcohol?

☐ Monthly or less ☐ 2-4 times a month

☐ 2-3 times a week ☐ 4 or more times a week

How many drinks did you have on a typical day?

☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks

☐ 7-9 drinks ☐ 10 or more drinks

How often did you have 6 or more drinks in one occasion?

☐ Never ☐ Less than monthly ☐ Monthly

☐ Weekly ☐ Daily or Almost Daily

Height: _____

Weight: _____

Shoe Size: _____

Women Only

Are you pregnant? ☐ Yes ☐ No

Are you breast feeding? ☐ Yes ☐ No

Review of Systems

Please select any symptoms you have had in the past 3 months.

General:

☐ Fever ☐ Weight Loss

☐ Chills ☐ Weight Gain

☐ Fatigue

Head:

☐ Headache ☐ Neck Pain

☐ Visual Problems ☐ Hearing Problems

Endocrine:

☐ Hot Flashes ☐ Heat Intolerance

☐ Excessive Sweating ☐ Cold Intolerance

☐ Changes in Hair/Skin Textures

Respiratory:

☐ Cough ☐ Wheezing

☐ Pain on Breathing ☐ Shortness of Breath

Cardiovascular:

☐ Chest Pain ☐ Palpitations

☐ Dizziness ☐Leg Pain when Walking

Gastrointestinal:

☐ Abdominal Pain ☐ Heartburn

☐ Difficulty Swallowing ☐ Change in Bowel Habits

Hematology:

☐ Bruising ☐ Abnormal Bleeding

☐ Blood Clots ☐ Delayed Healing

Urinary:

☐ Painful Urination ☐ Blood in Urine

☐ Frequent Urination ☐ Incontinence

Musculoskeletal:

☐ Painful Joints ☐ Swollen Joints

☐ Joint Stiffness ☐ Cramping

☐ Weakness

Skin:

☐ Rash ☐ Itching

☐ Wounds/Ulcers ☐ Skin Lesion(s)

Neurologic:

☐ Tingling/Numbness ☐ Tremor

☐ Seizures ☐ Paralysis

Psychiatric:

☐ Anxiety ☐ Depressed Mood

☐ Insomnia ☐ Memory Loss

The information provided is true to the best of my knowledge

Patient Name (please print): _____

Patient's Guardian (if applicable, print): _____

Patient or Guardian Signature: _____

Date: _____