## HEALTH QUESTIONNAIRE:

1. Patient Name: _____
2. Primary Care Physician _____
3. Physician Tel. #:_____
4. Referred to this office by _____
5. What is the reason for your visit?

   _____
   _____
   _____
6. Is this condition due to an injury? Yes ___ No ___
7. If yes, provide date, time and place of injury:

   _____
   _____
8. Please briefly describe how the injury occurred

   _____
   _____
   _____
   _____
9. Was this injury work related? Yes ___ No ___
10. If yes, have you reported this injury to your supervisor? Yes ___ No ___

## PAST MEDICAL HISTORY:

11. Please list any medical conditions that you are currently being treated for:

    _____
    _____
    _____
    _____
    _____
    _____
12. Have you ever been hospitalized or been under medical care overnight? Yes ___ No ___
13. If yes, please state the reason(s):

    _____
    _____
    _____
14. Have you had previous surgery? Yes ___ No ___
15. If yes, please list them:

    _____
    _____
    _____
    _____
    _____
16. Please list any known post-operative complications (delayed-healing, infection, anesthetic reaction, etc.)

    _____
    _____
    _____
    _____
    _____

## FAMILY HISTORY:

17. Please list medical illnesses in your family

    _____
    _____
    _____
    _____

## SOCIAL HISTORY:

18. Marital status:
    Single ___ Married ___ Separated ___
    Divorced ___ Widowed ___
19. With whom do you currently live?
    Family ___ Roommate ___ Alone ___
20. Alcoholic Beverages:
    Never ___ Rarely ___ Moderately ___ Daily ___
21. Tobacco use:
    Non-Smoker ___
    Smoker ___ Frequency (packs/day) ____
    Used To Smoke___ Year Quit _____
22. Other recreational drugs:

    _____
23. Employer: _____
24. Occupation: _____
25. Work address: _____
26. Work Phone number: _____

## SYSTEMIC REVIEW:

27. Current Height _____
28. Current Weight _____
29. When was your last physical? _____
30. Are your immunizations up to date? Yes ___ No ___
31. *For women only*:
    Number of pregnancies _____
    Number of miscarriages _____

**Source of information, if other than the patient:**

_____

**Signature of person acquiring this information:**

_____

**Signature of patient** **Date**

_____ _____

**Signature of parent/guardian** **Date**

_____ _____

Archstone
Foot & Ankle Institute

## PATIENT INFORMATION

1. Name: _____
2. Birthdate: Month ___ Day ___ Year _____ Age ____
3. Sex: M ___ F ___ Gender: _____
4. Social Security Number: _____
5. SSN of guardian (if minor): _____
6. Ethnicity: _____
7. Driver's License #: _____
8. Permanent Address:
   Street_____
   City_____State_____Zip_____
9. Home phone number: _____
10. Cell phone number: _____
11. Email address: _____
12. Preferred contact method: Phone call ___ Email ___
13. Preferred language: _____
14. Emergency contact: _____
    Phone Number: _____
    Relationship: _____

## INSURANCE INFORMATION

15. Insurance Provider: _____
16. Policy Number: _____

## MEDICATION LIST

17. Name of Patient's Pharmacy: _____
18. Pharmacy Address: _____
19. Pharmacy Telephone:_____
20. Known Allergies: _____

_____

❑ I have no allergies

❑ I am not currently taking any medication.

| Medication | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**PAY BENEFITS, PAYMENT OF SERVICES: The information provided above is true to the best of my knowledge. I understand that professional fees are due at the time services are rendered. These include but are not limited to co-pays, deductibles, self-payment and all discount plan payments. I hereby authorize my insurance benefits to be paid directly to the physician: Stephen C. Wan, D.P.M., Chul Kim, D.P.M., Brian Park, D.P.M., Michael Bloch, D.P.M., Roland Carroll, D.P.M., Alexander Perez, D.P.M., and Jeffrey Tseng, D.P.M. for the surgical and / or medical benefits, if any otherwise payable to me for his services. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Archstone Foot and Ankle Institute and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand my balance owed may increase.**

**Signed (insured person)**_____**Date**_____

*ARCHSTONE FOOT AND ANKLE INSTITUTE*
*2780 Skypark Dr., Suite 100, Torrance, California 90505 (310) 326-8551 Fax (310) 326-3363*

***ARCHSTONE FOOT AND ANKLE INSTITUTE***

*Injuries, Diseases and Surgery of the Foot and Ankle*
*Infants, Children, & Adults*

## MISSED APPOINTMENT POLICY

We thank you for choosing us as your healthcare provider. In order to give you and all our patients, the best possible care, we request you review our policy regarding missed appointments. **A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours.** Please remember that we have reserved appointment times especially for you.

If you are unable to keep your scheduled appointment time, we request you please call our office at least 24-hours in advance in order to avoid a missed appointment fee. If you fail to give us notice, you will be charged a **$20.00** missed appointment fee. **This charge is not covered by insurance.**

I have read and understand the policy stated above

_____
Patient/Guardian Signature

_____
Date

_____
Patient Printed Name

## PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical imaging to be made of me or my child (or for person whom I am legal guardian). I understand that the information may be used and shown in my medical record and for purposes of medical education of medical professionals, staff and patients at medical conferences, in office and via electronic publication. By consenting to this medical photography I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

_____
Patient/Guardian Signature

_____
Date

_____
Patient Printed Name

❑ I agree to the use of my image for medical records ONLY

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____
Patient/Guardian Signature

_____
Date

_____
Patient Printed Name