Archstone
Foot & Ankle Institute

Michael S. Bloch, D.P.M.
Roland J. Carroll, III, D.P.M.
Chul Kim, D.P.M.
Brian C. Park, D.P.M., Q.M.E.
Alexander R. Perez, D.P.M.

2780 Skypark Drive
Suite 100
Torrance, CA 90505

(310) 326-8551
(310) 326-3363
www.archstonepodiatry.com
info@feetandankles.com

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 ___ Used to Smoke ___
    Frequency (packs/day) ____ Year Quit _____
22. Other recreational drugs: _____

    _____
23. Employer: _____
24. Occupation: _____
25. Work Address: _____
26. Work Phone#: _____

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 patient:

_____

Signature of person acquiring this information:

_____

Signature of Patient:

_____

Signature of Patient's Guardian or Parent:

_____

Date:

_____

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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: Email____ Phone call____
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 medications

Medication	Dosage

PAY BENEFITS, PAYMENT OF SERVIES: 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: Chul Kim, D.P.M., Brian Park, D.P,M., Michael Bloch, D.P.M., Roland Carroll, D.P.M., and Alexander Perez, 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 relase 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** _____

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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 48-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 48 hours in advance in order to avoid a missed appointment fee. If you fail to give us notice, you will be charged a $25.00 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 purposed 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

ACKNOWLEDGEMENT 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

GENERAL CONSENT TO CARE

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by and Archstone Foot and Ankle Specialist provider, on an outpatient/office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider or the designees under the directions of a physician, as deemed reasonable and necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Archstone Foot and Ankle Group.

Patient / Guardian Signature

Date

Patient Printed Name