

SABGHIR PODIATRY, PC

Arianna Sabghir, DPM

WELCOME TO OUR OFFICE – Please Fill Out Completely

Patient Information (please print)

Today's Date _____

Name _____ Date of Birth _____ Age _____

Address _____ Apt _____ Cell Phone # _____

City/State _____ Zip _____ Home Phone# _____

Social Security # _____ E- Mail _____

Occupation _____ Employed by _____

Address _____ City/State _____ Zip _____

Work Phone _____ **Referred to our office by whom?** _____

Primary Care Physician: _____ Address _____ Phone# _____

Emergency Contact: _____ Relationship to patient: _____

Phone#: _____ Email: _____

(Minors under the age of 18)

Parent/Guardian: _____ **Phone #:** _____

Please read the following carefully and sign below:

I, the undersigned, request that payment of authorized Medicare or other health insurance benefits be made on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the health care planning administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item #12 on the HCFA-1500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for the deductible, co-insurance and non-covered services. I hereby acknowledge and understand that I am financially and fully responsible for all deductible co-insurance and non-covered charges incurred from the services rendered by my physician.

This Medicare authorization is effective during 2019-2022

I, agree to receive text and email notifications from the practice.

A copy of the following information has been made available to me: The ownership of the practice, the expertise of the staff physician; the practice's DNR Policy, Grievance Policy, and Patient Rights and Responsibilities.

X _____
Patient / Guardian Signature

What is the chief problem for which you came to be treated? (please include all foot, ankle, knee, thigh and hip complaints)

Please continue on next page

MEDICAL AND PODIATRIC INFORMATION:

PATIENT: _____

DOB: _____

Are you now, or have you been, under another doctor's care (internist/vascular/orthopedic/etc.) for any reason over the past two years?

Yes No

If yes, please explain: _____

SEX: Male Female Height _____ Weight _____ Shoe Size _____

ALLERGIES: (please select all that apply) None Aspirin/NSAIDs Penicillin Latex Local Anesthetics
 Adhesive Tape Iodine Seafood Other (Explain): _____

MEDICATIONS: (Please include over-the-counter, vitamins and homeopathic preparations): _____

PREFERRED PHARMACY: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

History of DIABETES: Self? Yes No Family? Yes No

Athletic activities in which you participate: _____

Have you ever been treated for any of the following? (Please select all that apply)

Neuropathy Heart Problems Asthma Epilepsy Tuberculosis Cancer Liver Problems
 Poor Circulation Liver Problems High / Low Blood Pressure Cerebral Palsy Down Syndrome
 Ulcers Osteoporosis Arthritis Phlebitis Obsessive-Compulsive Disorder Kidney Problems
 Autism Spectrum Disorder Sensory Processing Disorder Unspecified Developmental Delay

• Do you have severe chest pain or shortness of breath? Yes No

• Are you subject to bleeding disorders? Yes No

• Have you ever fainted in a doctor's or dentist's office? Yes No

• Has your body weight significantly changed in the past 5 years? (more than 10%) Yes No

• Do you have low back pain? Yes No

• Tobacco Use? No Yes (select all that apply) Cigarettes Cigars Marijuana Chewing

• Alcohol Use? No Yes (select all that apply) Beer Wine Hard Liquor

• Women: Is there any possibility that you are currently pregnant? Yes No

Thank you