Palm Springs Podiatry / 707 E. Tahquitz Canyon Way, Ste G-9 / Palm Springs, CA 92262
Phone: 760-507-4000 / Fax: 760-406-5714

Patient Demographics

Date of Birth:__________________________ SSN:_____________________________

Full Name:____ Gender: ☐M ☐F ☐Other
First Middle Initial Last

Address:____
Unit #

____
City State Zip

Phone Number:______________________________ _____________________________
Primary Secondary

Marital Status:☐Married ☐Single ☐Other Email Address:_______________________________

Emergency Contact:_________________________ Number:_______________________

Employer Name/Occupation:____

Referred by:_____________________________ Preferred Pharmacy:_________________

Primary Physician:___________________________ Number:________________________

Insurance

Primary Insurance:____

ID#:______________________________ Group:___________________________________

Insurance Address: __________________________Guarantor's D.O.B.:_____________

Secondary Insurance:____

ID #:_______________________________ Group #:________________________________

Insurance Address:_____________________________ Guarantor's D.O.B.___________

Medical History

Are you currently under your physicians' care? If yes, for what reason?
Name of Doctor: ____

____

____

Have you has previous treatment by a podiatrist? If yes, for what reason?

____

____

What is your chief complaint for seeing the podiatrist today?

____

____

Do you have any allergies? Please include prescription medication, over the counter medicines, adhesives, tape, food, seasonal, etc...

____

____

Please list all medications you are currently taking:

____

____

Please list any herbal or dietary supplements you are currently taking.

____

Are you pregnant? If so, what is your expectant due date?

____

Please list all surgeries you have had in the past:

____

____

Have you ever been hospitalized? If so, please list dates and reason.

____

____

Is there anything else you would like to mention about your visit today?

____

____

Patient Information & Health History

My chief foot complaint is: ____

How long has the condition existed? ____

Symptoms: ____

Which Side: Right _____ Left____ Both_____

Type of Pain: Dull____ Achy____ Throbbing____ Sharp____ Burning____ Shooting____

Area of Pain: ____

Since your pain began, has it gotten: Better____ Worse____ Stayed the same ____

What aggravates your condition? Walking ____ Running _____ Standing _____ Wearing Shoes_____

What have you tried to help the pain? New shoes________ Anti-Inflammatory________
Decrease in activities________ Ice_______ Arch Supports_______ Orthotics________ Stretches_________
Other____

Onset of Pain: Slow_____ Sudden_____ Traumatic_____

Weight: _____________________ Height: ______________________ Shoe Size: ______________________

Do you smoke tobacco? Yes____ No____

Smoking duration: ___ Days___ Weeks ____Years Packs: ____Day _____Week

Do you drink alcohol: Yes____ No_____
If so, how many days/drinks per week: Days_____ Avg # of Drinks _____

Recreational Drugs: Yes____ No____
If so, what type? ____

Please mark YES or NO to indicate if you or a family member has had the following:

	PERSONAL		FAMILY	
Alcoholism	Yes	No	Yes	No
Anenia	Yes	No	Yes	No
Arthritis: Type: ____________________	Yes	No	Yes	No
Artificial Heart Valve/Joints: Type _______	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Back Problems	Yes	No	Yes	No
Bleed Easily	Yes	No	Yes	No
Cancer: Type________________	Yes	No	Yes	No
Chemical Dependency	Yes	No	Yes	No
Chest Pain	Yes	No	Yes	No
Circulatory Problems	Yes	No	Yes	No
Depression	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Eating Disorder	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No
Fibromyalgia	Yes	No	Yes	No
Gout	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
Hemophilia	Yes	No	Yes	No
Hepatitis	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
HIV Positive	Yes	No	Yes	No
Kidney Problems	Yes	No	Yes	No
Leg Cramps	Yes	No	Yes	No
Liver Disease	Yes	No	Yes	No
Lung Respiratory	Yes	No	Yes	No
Menopause	Yes	No	Yes	No
Mental Illness	Yes	No	Yes	No
Psychiatric	Yes	No	Yes	No
Phlebitis/Clots	Yes	No	Yes	No
Psoriasis	Yes	No	Yes	No
Rheumatic Fever	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Thyroid Problems	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No
Ulcers-Stomach	Yes	No	Yes	No
Venereal Disease	Yes	No	Yes	No
Weight Change	Yes	No	Yes	No

Authorization for Treatment and Financial Agreement

I hereby consent to and authorize all treatment that may be necessary to and advisable by Dr. Bobby Pourziaee and his staff. I understand that no guarantee or assurance has been made as to the results that may be obtained. I understand that charges will be made for the office visit and other procedures such as x-rays, laboratory examinations, etc... and hereby agree that I am financially responsible for any charges not covered by my health care plan. I hereby authorize the Doctor to release all information necessary to secure the payments of health care benefits.

Patient Name:____

Patient Signature: ____

Date:_______________________

Parent/Guardian Name & Signature (if applicable):

____

Date:_______________________

Cancellation Policy

A **$35.00 Cancellation fee** will be applied to appointments not cancelled within 24 hours. This fee pertains to ALL appointments.

Patient Name:____

Patient Signature: ____

Date:______________________

Parent/Guardian Name & Signature (if applicable):

____

Date:______________________

Acknowledgement of receipt of Notice of Privacy Practice

I acknowledge that I was provided a copy of the Notice of Privacy Practices by Dr. Bobby Pourziaee, D.P.M. and that I have read, or had the opportunity to read if I so choose and understand the Notice.

Patient Name:____

Patient Signature: ____

Date:_______________________

Parent/Guardian Name & Signature (if applicable):

____

Date:_______________________

PATIENT AUTHORIZATION FOR PHOTO OR VIDEO

I, ____________________________, authorize Palm Springs Podiatry to photograph or video record my foot, ankle or leg region to use such materials in its sole discretion and in any manner including, but not limited to; tracking medical progress, social media use, informing the public about services provided, the circumstances surrounding same and the medical care and treatment that I have been receiving and/or will receive in the future. I understand and acknowledge that any photograph, videotape or printed or published materials could be reproduced by unknown persons or organizations and republished via internet or other media without my knowledge or consent. Palm Springs Podiatry has made no representations, promises or assurances to me about potential use of any materials and I have not relied on any statements by any representatives of Palm Springs Podiatry in deciding to participate. I waive any claims against Palm Springs Podiatry for any compensation for use of any such materials and waive any claims against Palm Springs Podiatry relating to use, publication or broadcast of any materials.

Further, I authorize Palm Springs Podiatry and/or its subsidiaries, partnerships, limited partners, general partners, parent companies or affiliates, including but not limited to Bobby Pourziaee DPM, Inc. to hereby waive any right to compensation for Palm Springs Podiatry's use such materials which may display my likeness, photographs, image, voice, statements and name and release Palm Springs Podiatry and its employees and agents, including any physicians or other health care providers, from liability for any causes of action or claims of damages relating to Palm Springs Podiatry's use of such materials including, but not limited to any claims of invasion of privacy, defamation, infringement of my right of publicity or copyright infringement.

Patient Name:____

Patient Signature: ____

Date:______________________

Parent/Guardian Name & Signature (if applicable):

____

Date:______________________