WELCOME

Name: ________________________________ Sex: M F **Date of Birth:** / /

Street: ____ E-mail: ____________________________

City: ________________ State: _____ Zip:_______

Home Phone: ( ) ________-_________ Work Phone: ( ) _______- _________

Cell Phone: ( ) _________-_________

In case of emergency notify: _______________ Phone: ( ) _________-_________

Primary Doctor (name and telephone): ____

What **foot** condition brings you to our office today?____

Are you allergic to any medication? ____

List any medication you are taking: ____

____

Do you have any medical problems? ____

What activities do you do during the week? ____

Social Security Number: ______-________-________

How did you hear about us? ____

Method of payment: CASH, BLUE SHIELD, BLUE CROSS, HEALTHNET, PHCS, AETNA, CIGNA, UNITED HEALTHCARE, SAG

Primary Insurance Company: ____________ Policy#: ________________________ Group#:____________

Secondary Insurance Company: __________ Policy#:_________________________ Group#: ___________

I HERBY AUTHORIZE THE DIRECT PAYMENT OF MEDICAL BENEFITS TO *SEAN S. RAVAEI*, DPM FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY BALANCE NOT COVERED BY MY INSURANCE.
I HERBY AUTHORIZE SEAN S. RAVAEI, DPM TO RELEASE MY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY TO EITHER MEDICAL CARE OF IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT. I CERTIFY THAT THE INFORMATION GIVEN TO ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF ALL RECORDS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I UNDERSTAND THAT HONEST AND COMPLETE ANSWERS TO EACH QUESTION ABOVE ARE IMPORTANT TO MY MEDICAL CARE AND I HAVE ANSWERED THEM TO THE BEST OF MY ABILITY. I HAVE BEEN INFORMED THAT IF I AM UNCERTAIN ABOUT ANY QUESTIONS I SHOULD ASK THE DOCTOR FOR ASSISTANCE. SHOULD I FAIL TO PAY MY BILL I AM FULLY RESPONSIBLE FOR THE COLLECTION FEE THAT DR. RAVAEI WILL INCUR.

Patient Signature: ______________________________________**Today's Date:** __ /_ _/____

Patient guardian signature if patient is under the age of 18: ____

Do or anyone in your family have any of these conditions:

1. High blood pressure No_____ Yes_____ Family_____
2. Scarlet fever or Rheumatic fever No_____ Yes_____ Family_____
3. Bleed easily from cuts, tooth extraction No_____ Yes_____ Family_____
4. Bruise easily No_____ Yes_____ Family_____
5. Slow or poor healer No_____ Yes_____ Family_____
6. Tendency to form large scars(keloid) No_____ Yes_____ Family_____
7. Diabetes No_____ Yes_____ Family_____
8. Heart problem No_____ Yes_____ Family_____
9. Thyroid problems No_____ Yes_____ Family_____
10. Shortness of breath No_____ Yes_____ Family_____
11. Abdomen or stomach problem No_____ Yes_____ Family_____
12. Change in vision No_____ Yes_____ Family_____
13. Ear, Nose or throat problems No_____ Yes_____ Family_____
14. Heart Problems No_____ Yes_____ Family_____
15. Painful/leaking/bloody urination No_____ Yes_____ Family_____
16. Muscle or joint pain No_____ Yes_____ Family_____
17. Skin cancer or any skin disease No_____ Yes_____ Family_____
18. Headache, memory loss or fainting No_____ Yes_____ Family_____
19. Anxiety/stress/sleep problems No_____ Yes_____ Family_____
20. Easily Bruising No_____ Yes_____ Family_____
21. Unexplained lumps No_____ Yes_____ Family_____
22.Increase thirst/appetite No_____ Yes_____ Family_____
23. Cold/ heat Intolerance No_____ Yes_____ Family_____

If you answered yes, to any questions above please explain here:

Is there any condition that we have not listed and you like to share with us? This will help us render the best care to you.

Patient signature____ Date_______________________