FALLBROOK PODIATRY INC.

407 Potter Street, Suite A • Fallbrook, CA 92028 • (760) 728-4800 • softtoesmile@gmail.com • fallbrookfootdoctor.com

PATIENT INTAKE FORM

Please complete all sections as accurately as possible.

PATIENT: _____ _____ _____

FIRST NAME M.I. LAST NAME

DEMOGRAPHICS

HEIGHT: _____ ft _____ in WEIGHT: _____ lbs SHOE SIZE: _____ GENDER: ☐ M ☐ F

OCCUPATION: _____ FORMER OCCUPATION: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMAIL: _____

HEALTHCARE PROVIDERS

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

CARDIOLOGIST: _____ ENDOCRINOLOGIST: _____

NEPHROLOGIST: _____ RHEUMATOLOGIST: _____

INSURANCE INFORMATION

Please skip this section if we already have a copy of your insurance card.

PRIMARY INSURANCE

INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ DOB: _____

MEMBER ID / SSN: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ DOB: _____

HOW DID YOU FIND US?

☐ Friend/Relative ☐ Google ☐ Yelp ☐ ChatGPT/AI ☐ Friends of Fallbrook

☐ Yellow Pages ☐ Other: _____

ARE YOU PREGNANT? ☐ YES ☐ NO If yes, how many months? _____ (Congratulations!)

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PATIENT: _____ _____ _____

FIRST NAME M.I. LAST NAME

HISTORY OF PRESENT FOOT / ANKLE PROBLEM

Check all that apply:

- ☐ Ingrown Nails
- ☐ Heel Pain
- ☐ Bunions
- ☐ Nail Fungus
- ☐ Joint Pain/Stiffness
- ☐ Hammertoes
- ☐ Warts
- ☐ Leg/Ankle Swelling
- ☐ Flat Feet

WHICH SIDE: ☐ Right ☐ Left ☐ Both WHICH TOE: _____

HOW LONG HAS THE PROBLEM BEEN PRESENT? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

HAVE YOU SEEN SOMEONE FOR THIS ALREADY? ☐ No ☐ Yes, whom: _____

ALLERGIES

FOOD ALLERGIES: _____ TAPE ALLERGIES: _____

☐ Aspirin	☐ Lidocaine	☐ Novocain	☐ Penicillin	☐ Cipro
☐ Iodine	☐ Codeine	☐ Vicodin	☐ Sulfa Drugs	☐ Shellfish
☐ Shrimp	☐ Citrus	☐ Hay Fever	☐ Tape	☐ Adhesive
☐ Latex	☐ Long Intake Forms	☐ Other: _____		

OTHER REACTIONS / SENSITIVITIES: _____

CURRENT MEDICATIONS

List all current medications and dosages (or hand your medication list to the front office):

1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

PREFERRED PHARMACY: _____ PHONE: _____

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PATIENT: _____ _____ _____

FIRST NAME M.I. LAST NAME

MEDICAL HISTORY

Check all conditions that apply to you now or have applied in the past:

- ☐ Anemia/Blood Disorders
- ☐ Arthritis
- ☐ Asthma/Hay Fever/SOB
- ☐ Blood Clots
- ☐ Chest Pain on Exertion
- ☐ Cerebral Palsy/Polio
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Dialysis
- ☐ Drug/Alcohol Abuse
- ☐ Ear/Nose/Throat Disorder
- ☐ Emotional Problems
- ☐ Skin Problems
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Eye Problems
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ HIV
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Prostate Disorder
- ☐ Psychiatric Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ STD
- ☐ Stomach/Ulcer Disorder
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Tumor/Cancer
- ☐ Heart Problems
- ☐ Other: _____

If Diabetic: Years: _____ Avg Blood Sugar: _____ HbA1C: _____

SURGICAL HISTORY

Procedure / Injury / Illness	Year	Physician	Hospital

FAMILY HISTORY

	Cancer	Heart	Blood Press.	Stroke	Clots	Kidney	Diabetes	Mental	Emphys.
MATERNAL	☐	☐	☐	☐	☐	☐	☐	☐	☐
PATERNAL	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

DO YOU SMOKE CURRENTLY? ☐ Yes ☐ No Years: _____ Packs/Day: _____

DID YOU SMOKE PREVIOUSLY? ☐ Yes ☐ No Quit: _____

CAFFEINE DRINKS/DAY: _____ ALCOHOL/WEEK: _____

ILLICIT DRUGS? ☐ Yes ☐ No _____ VAPING? ☐ Yes ☐ No _____

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PATIENT: _____ _____ _____

FIRST NAME M.I. LAST NAME

COMPREHENSIVE REVIEW OF SYSTEMS

Check all symptoms that currently apply to you:

CONSTITUTIONAL

- ☐ Appetite Decrease
- ☐ Appetite Increase
- ☐ Chills
- ☐ Convulsions/Seizures
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Sleep Problems
- ☐ Weight Gain
- ☐ Weight Loss

CARDIOLOGICAL

- ☐ Ankle Swelling
- ☐ Calf Cramping
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Jaw Pain
- ☐ Murmur
- ☐ Pacemaker
- ☐ Shortness of Breath

ENDOCRINE

- ☐ Cold Intolerance
- ☐ Dry Hair
- ☐ Dry Skin
- ☐ Extreme Thirst
- ☐ Heat Intolerance
- ☐ Hot Flashes
- ☐ Hyperglycemia
- ☐ Recent Hair Loss
- ☐ Unusual Fatigue

ENT

- ☐ Chronic Cough
- ☐ Hearing Difficulty
- ☐ Swallowing Difficulty
- ☐ Lost Sense of Smell
- ☐ Post-Nasal Drip
- ☐ Recent Nose Bleed
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Swollen Neck Glands
- ☐ Tinnitus

EYES

- ☐ Bifocals
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Farsighted
- ☐ Loss of Vision
- ☐ Nearsighted
- ☐ Photosensitivity

GASTROINTESTINAL

- ☐ Abdomen Pain
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gastric Reflux/Heartburn
- ☐ Nausea

GENITOURINARY

- ☐ Bladder Spasm
- ☐ Blood in Urine
- ☐ Burning with Urination
- ☐ UTI
- ☐ Kidney Problems
- ☐ Ovarian Cysts
- ☐ Prostate Problems
- ☐ Urinary Frequency
- ☐ Urinary Urgency
- ☐ Uterine Fibroids

IMMUNOLOGIC

- ☐ Arthritic Flare-up
- ☐ Recent Asthma Attack
- ☐ Sneezing
- ☐ Environmental Allergies
- ☐ Eyes Watering
- ☐ Seasonal Allergies

INTEGUMENTARY

- ☐ Burning of Skin
- ☐ Dandruff
- ☐ Dermatitis
- ☐ Eczema
- ☐ Excessive Scar Tissue
- ☐ Hypersensitivity/Rash
- ☐ Non-healing Wounds
- ☐ Psoriatic Flare-up
- ☐ Tingling Sensation

LYMPHATIC

- ☐ Anemia
- ☐ Ankle Edema
- ☐ Bleeding Tendency
- ☐ Bruise Easily
- ☐ Leg Swelling
- ☐ Recent Sickle Cell Crisis
- ☐ Recent Transfusion
- ☐ Swollen Lymph Nodes

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Leg Cramps
- ☐ Morning Stiffness
- ☐ Muscle Tenderness
- ☐ Neck Pain
- ☐ Stiffness
- ☐ Muscle Weakness
- ☐ Difficulty Walking

NEUROLOGICAL

- ☐ Burning Toes/Fingers
- ☐ Hypersensitivity
- ☐ Neurological Problems
- ☐ Numbness
- ☐ Tremors
- ☐ Paralysis
- ☐ Recent Seizure
- ☐ Stocking/Glove Numbness
- ☐ Tingling Extremities
- ☐ Uncontrolled Movements

PSYCHIATRIC

- ☐ Addictive Tendencies
- ☐ Anger Issues
- ☐ Anxiousness
- ☐ Attempted Suicide
- ☐ Claustrophobia
- ☐ Constant Overeating
- ☐ Depression
- ☐ Disorientation
- ☐ Irritability
- ☐ Libido Decrease
- ☐ Memory Loss
- ☐ Mental Status Changes
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Poor Sleep Pattern
- ☐ Suicidal Thoughts

RESPIRATORY

- ☐ Breathing Difficulties
- ☐ Respiratory Symptoms
- ☐ Chest Pain/Inspiration
- ☐ Wheezing
- ☐ Snoring
- ☐ Recent Asthma Attack
- ☐ Recent TB Exposure
- ☐ Shortness of Breath
- ☐ Sleep Apnea

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FIRST NAME M.I. LAST NAME

SIGNATURES & CONSENT

SIGNATURE OPTIONS: (1) Print this form and sign with pen OR (2) Use Adobe Acrobat Reader (free) "Fill & Sign" feature to sign digitally

Date fields sync across all signature lines — enter once and it will populate everywhere.

1 ASSIGNMENT OF BENEFITS & AUTHORIZATION

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services, which would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for any charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs incurred in the collection of my account, including collection fees and attorney costs. A $25.00 per month re-invoicing fee will apply to all accounts 10 days past due. I permit a copy of this assignment to be used in place of the original for billing purposes. The information provided by me is true and correct to the best of my knowledge. I authorize the release of any previous medical records by fax, mail, or phone from any physician or hospital as needed. I also authorize the doctor and/or clinical staff to initiate the diagnosis and treatment of my condition, including the use of X-ray examinations or photographs as necessary. I give Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.) permission to obtain and release medical information to insurance companies and referring physicians. I have read the information provided and understand and agree to the office policies of Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.).

SIGNATURE: _____ DATE: _____

IF NOT PATIENT, RELATIONSHIP: ☐ Parent ☐ Power of Attorney ☐ Legal Guardian ☐ Other: _____

2 HMO INSURANCE (If you do not have an HMO, please initial — no full signature required)

All HMO patients must have a valid referral/authorization prior to each office visit. Failure to obtain a referral will result in the patient being financially responsible for all services rendered.

SIGNATURE/INITIALS: _____ DATE: _____

3 CANCELLATIONS AND MISSED APPOINTMENTS

A minimum of 24-hour notice is required to cancel or reschedule an appointment. Patients who do not provide 24-hour notice, or who fail to show for their appointment, will be assessed a $125 fee.

SIGNATURE: _____ DATE: _____

4 PRIVACY INFORMATION

May we leave appointment and medical information by way of message or email?

Patient Only?	☐ Y	☐ N	Patient and/or Spouse?	☐ Y	☐ N
Anyone Answering Home Phone?	☐ Y	☐ N	On Home Voice Mail?	☐ Y	☐ N
Via Email?					

OTHER INSTRUCTIONS: _____

SIGNATURE: _____ DATE: _____

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PATIENT: _____ _____ _____

FIRST NAME M.I. LAST NAME

SIGNATURES & CONSENT (CONTINUED)

5 RELEASE OF INFORMATION

By my signature, I authorize Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.) to disclose, when requested by any named insurance carriers or their authorized representatives, any and all information regarding any illness(es), injury(ies), medical history, treatment, and copies of medical records. I additionally authorize payment directly to Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.) of any surgical and/or medical benefits otherwise payable to me for professional services rendered. I understand that I am financially responsible for all charges not covered by this authorization. I further agree that, in the event of nonpayment, I will be responsible for any reasonable costs incurred in the collection of my account, including legal fees if required. A photocopy of this authorization shall be considered as valid as the original.

SIGNATURE: _____ DATE: _____

6 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read, or had the opportunity to read, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices, and that I understand the information provided.

SIGNATURE: _____ DATE: _____

If you have not had the opportunity to review the HIPAA Notice, a copy is available in our office.

7 CONSENT FOR: TREATMENT • OBSERVATION • PHOTO • TISSUE SAMPLING • TISSUE STUDY

I hereby consent to examination and treatment as indicated following my consultation with Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.). I understand that the use of any anesthetics, sedatives, X-rays, or surgical procedures deemed necessary by Dr. Patish will not be performed without prior discussion with me. I further consent to and authorize the performance of any additional surgical or non-surgical procedures or treatments that the doctor determines to be advisable during the course of care to achieve the intended medical outcome or to protect my health and well-being. I acknowledge that no guarantee or assurance has been made regarding the results that may be obtained. I consent to the administration of anesthesia as deemed advisable by the doctor. I consent to the use of radiologic procedures (X-rays), the taking of tissue samples for laboratory testing, and any additional services or testing deemed necessary for medical care. I consent to the proper disposal of any tissues or parts removed during treatment or surgical procedures. I understand that the use or abuse of drugs (prescribed or otherwise), alcohol, and tobacco—past or present—or the existence of conditions such as medication allergies, pregnancy, epilepsy, herpes, hepatitis, HIV/AIDS, or any other undisclosed medical conditions may put me at greater risk for complications, and I assume all risks that may result from my failure or refusal to disclose such information prior to treatment. I further understand that systemic conditions—including but not limited to diabetes, rheumatoid arthritis, peripheral vascular disease, and autoimmune disorders—may increase my risk of complications when undergoing surgical procedures. For the purpose of advanced podiatric medical education, I consent to the admittance of observers into the operating/procedure room and to the photographing and/or video recording of the surgical procedure(s). I acknowledge that I have had the opportunity to ask questions regarding my diagnosis, the planned procedures, potential risks, benefits, and alternatives, and that all of my questions have been answered to my satisfaction. I understand that I may revoke my consent at any time prior to treatment. I affirm that I have not been coerced or pressured to consent and that I am providing this authorization voluntarily. I acknowledge that I have received, or had the opportunity to receive, the Notice of Privacy Practices (HIPAA) for Fallbrook Podiatry Inc., and understand that my protected health information may be used or disclosed for the purposes of treatment, payment, and healthcare operations as permitted by law. By signing below, I consent to the proposed examination and/or treatment, and authorize Fallbrook Podiatry Inc. and Dr. Grigoriy N. Patish, D.P.M., to proceed with the medical or surgical care deemed necessary for my health and well-being.

SIGNATURE: _____ DATE: _____

YOU MADE IT. YOU ARE AWESOME.

Thank you for taking the time to complete this form thoroughly.