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 | MIDDLE INITIAL | LAST NAME

DEMOGRAPHICS

HEIGHT: _____ feet _____ inches WEIGHT: _____ pounds 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!)

PATIENT: _____ _____ _____
FIRST NAME MIDDLE INITIAL 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
- ☐ Gout
- ☐ Athlete's Foot
- ☐ You Think Your Feet Are Ugly

TRAUMA / OTHER:

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

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

HAVE YOU HAD ANY TREATMENT OR TAKEN ANYTHING FOR IT?

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

PREFERRED PHARMACY: _____ PHONE: _____

PATIENT: _____ _____ _____

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

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

SURGICAL HISTORY

Procedure / Injury / Illness	Year	Physician	Hospital

FAMILY HISTORY

	Cancer	Heart Disease	High Blood Pressure	Stroke	Blood Clots
MATERNAL	☐	☐	☐	☐	☐
PATERNAL	☐	☐	☐	☐	☐

	Kidney Disease	Diabetes	Mental Illness	Emphysema
MATERNAL	☐	☐	☐	☐
PATERNAL	☐	☐	☐	☐

SOCIAL HISTORY

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

DID YOU SMOKE PREVIOUSLY? ☐ Yes ☐ No When did you quit? _____

CAFFEINE DRINKS PER DAY: _____ ALCOHOL CONSUMED PER WEEK: _____

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

PATIENT: _____ _____ _____

FIRST NAME | MIDDLE INITIAL | 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
- ☐ Nose Bleed
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Swollen 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 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 Skin
- ☐ Dandruff
- ☐ Dermatitis
- ☐ Eczema
- ☐ Excessive Scarring
- ☐ Skin Rash
- ☐ Non-healing Wounds
- ☐ Psoriasis Flare-up
- ☐ Tingling Sensation

LYMPHATIC

- ☐ Anemia
- ☐ Ankle Edema
- ☐ Bleeding Tendency
- ☐ Bruise Easily
- ☐ Leg Swelling
- ☐ 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
- ☐ Overeating
- ☐ Depression
- ☐ Disorientation
- ☐ Irritability
- ☐ Libido Decrease
- ☐ Memory Loss
- ☐ Mental Status Changes
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Poor Sleep
- ☐ Suicidal Thoughts

RESPIRATORY

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

PATIENT: _____ _____ _____

FIRST NAME | MIDDLE INITIAL | LAST NAME

SIGNATURES & CONSENT

1 ASSIGNMENT OF BENEFITS & AUTHORIZATION

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services. 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 authorize the release of any previous medical records 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. 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.

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?	☐ Y	☐ N	On Cell Voice Mail?	☐ Y	☐ N

OTHER INSTRUCTIONS: _____

SIGNATURE: _____ DATE: _____

PATIENT: _____ _____ _____

FIRST NAME | MIDDLE INITIAL | 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. of any surgical and/or medical benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by this authorization. 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. 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, 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. I understand that I may revoke my consent at any time prior to treatment. By signing below, I consent to the proposed examination and/or treatment.

SIGNATURE: _____ DATE: _____

YOU MADE IT. YOU ARE AWESOME.

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