PATIENT: _____

FIRST NAME *M.I.* *LAST NAME*

PLEASE FILL OUT THE INFORMATION AS DETAILED & LEGIBLE AS POSSIBLE. THANK YOU.

HEIGHT: _____**FEET** _____**INCHES OR** _____ **CM** **WEIGHT:** _____**LBS / KG** **SHOE SIZE & WIDTH:** _____

OCCUPATION: _____**FORMER OCCUPATION:** _____ **GENDER** ☐**M** ☐**F** _____

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

ADDRESS_____

CITY: _____**STATE**_____**ZIP**_____

HOME PHONE:_____**WORK PHONE:**_____**CELL PHONE:**_____

EMERGENCY CONTACT: _____**PHONE/CELL PHONE:** _____

E-MAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN:_____**PHONE:**_____

CARDIOLOGIST: _____**ENDOCRINOLOGIST:** _____

NEPHROLOGIST: _____**RHEUMATOLOGIST:** _____

PLEASE SKIP INSURANCE INFORMATION SECTION IF WE HAVE A COPY OF YOUR INSURANCE CARD

PRIMARY INSURANCE COMPANY: _____

POLICY HOLDER'S NAME _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S MEMBER'S ID NUMBER AND SOCIAL SECURITY_____

SECONDARY INSURANCE COMPANY: _____

POLICY HOLDER'S NAME _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER_____

PLEASE PROVIDE YOUR INSURANCE CARDS AND PHOTO ID (DRIVER'S LICENSE) TO THE FRONT OFFICE MANAGER

HOW DID YOU FIND US?

☐ **FRIEND / RELATIVE REFERAL**_____

INTERNET: ☐**GOOGLE** ☐**YAHOO** ☐**YELP** ☐**CHATGPT/AI** ☐**FRIENDS OF FALLBROOK** ☐**FALLBROOK YELLOW PAGES**

☐**RIVERSIDE YELLOW BOOK** ☐**OTHER**_____

ARE YOU PREGNANT? (CHECK ONE) **YES**☐ **NO**☐ IF YES → **HOW MANY MONTHS? _____(CONGRATULATIONS!)**

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
☐ GOUT	☐ ATHLETES 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 / MONTH / YEARS

HAVE YOU HAD ANY TREATMENT OR TAKEN ANYTHING FOR IT? _____

_____

HAVE YOU SEEN SOMEONE FOR THIS ALREADY? ☐NO ☐YES WHOM? _____

_____

PEASE MARK AND LIST ALL ALLERGIES: FOODS: _____TAPES_____

☐**ASPIRIN** ☐**LIDOCAINE** ☐**NOVOCAIN** ☐**PENICILLIN** ☐**CIPRO** ☐**IODINE** ☐**CODEINE** ☐**VICODIN** ☐**SULFA DRUGS**

☐**SHELLFISH** ☐**SHRIMP** ☐**CITRUS** ☐**HAY FEVER** ☐**TAPE** ☐**ADHESIVE** ☐ **LATEX** ☐**LONG INTAKE FORMS**

OTHER: WHAT TYPES OF OTHER REACTIONS / SENSITIVITIES HAVE YOU EXPERIENCED? _____

_____

MEDICATIONS AND THE DOSAGES: (IF YOU HAVE A LIST, PLEASE HAND IT TO FRONT OFFICE MANAGER TO COPY, NO NEED TO FILL OUT)

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

PREFERRED PHARMACY:_____ **PHONE#:** _____

FIRST NAME *M.I.* *LAST NAME*

MEDICAL HISTORY:

CHECK / CIRCLE THOSE THAT APPLY TO YOU NOW OR HAVE APPLIED TO YOU IN THE PAST

- ☐ ANEMIA/BLOOD DISORDERS/ BLEEDING DISORDERS
- ☐ ARTHRITIS
- ☐ ASTHMA / HAY FEVER / SHORTNESS OF BREATH
- ☐ BLOOD CLOTS
- ☐ CHEST PAIN ON MILD EXERTION
- ☐ CEREBRAL PALSY OR POLIO
- ☐ DIABETES I or ☐ DIABETES II X _____YEARS
- ☐ DIALYSIS M W F OR T TH SA
- ☐ DRUG/ALCOHOL ABUSE
- ☐ EAR, NOSE, THROAT DISORDER
- ☐ EMOTIONAL PROBLEMS/TENSION
- ☐ SKIN PROBLEMS: DRY PSORIASIS DERMATITIS
- ☐ EMPHYSEMA
- ☐ EPILEPSY OR SEIZURES
- ☐ EYE (CATARACTS, GLAUCOMA)
- ☐ GOUT
- ☐ HEADACHES/MIGRAINES
- ☐ HEART PROBLEMS
- ☐ HIV
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ KIDNEY DISEASE (STONES, INFECTION)
- ☐ LIVER DISORDER (CIRRHOSIS, HEPATITIS)
- ☐ PNEUMONIA

AVERAGE BLOOD SUGAR = _____ HBA1C = _____

- ☐ PROLONGED BLEEDING TIME
- ☐ PROSTATE DISORDER
- ☐ PSYCHIATRIC TREATMENT
- ☐ RHEUMATIC / SCARLET FEVER
- ☐ SEXUALLY TRANSMITTED DISEASE / SYPHILIS / GONORRHEA
- ☐ STOMACH/ULCER DISORDER
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ THYROID/PARATHYROID DISEASE
- ☐ TUMOR/ABNORMAL GROWTH/CANCER
- ☐ OTHER_____

SURGICAL HISTORY

SURGICAL PROCEDURES/SERIOUS INJURIES/ILLNESSES	YEAR	PHYSICIAN	HOSPITAL

FAMILY HUSTORY – PLEASE CHECK (X) ANY FAMILY MEDICAL HISTORY

	CANCER	HEART	BLOOD PRESSURE	STROKE	BLOOD CLOTS	KIDNEY	DIABETES	MENTAL	EMPHYSEMA
MATERNAL	☐	☐	☐	☐	☐	☐	☐	☐	☐
PATERNAL	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

DO YOU SMOKE CURRENTLY? ☐ YES ☐ NO HOW MANY YEARS? _____ PACKS/DAY?_____

DID YOU SMOKE PREVIOUSLY? ☐ YES ☐ NO WHEN DID YOU QUIT?_____HOW MANY YEARS?_____PACKS/DAY?_____

NUMBER OF CAFFEINE DRINKS PER DAY? _____ AMOUNT OF ALCOHOL CONSUMED PER WEEK_____

ILLICIT DRUGS? ☐ YES ☐ NO _____ VAPING? ☐ YES ☐ NO _____

COMPREHENSIVE REVIEW OF SYSTEMS - PLEASE CHECK ALL 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: ☐ COUGH, CHRONIC, ☐ DIFFICULTY WITH HEARING, ☐ DIFFICULTY WITH SWALLOWING, ☐ LOST SENSE OF SMELL, ☐ POST-NASAL DRIP, ☐ RECENT NOSE BLEED, ☐ RINGING IN EARS, ☐ SINUS PROBLEMS, ☐ SORE THROAT, ☐ SWOLLEN OR PAINFUL 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.

GENITO/URINARY: ☐ BLADDER SPASM, ☐ BLOOD IN URINE, ☐ BURNING WITH URINATION, ☐ URINARY TRACT INFECTION ☐ KIDNEY PROBLEMS OR DISORDER OVARIAN CYSTS, ☐ PROSTATE PROBLEMS, ☐ URINARY FREQUENCY, ☐ URINARY URGENCY, ☐ UTERINE FIBROIDS.

IMMUNOLOGIC: ☐ ARTHRITIC FLARE-UP, ☐ ASTHMA ATTACK RECENTLY, ☐ SNEEZING, ☐ ENVIRONMENTAL ALLERGIES, ☐ EYES WATERING, ☐ SEASONAL ALLERGIES.

INTEGUMENTARY: ☐ BURNING OF THE SKIN, ☐ DANDRUFF, ☐ DERMATITIS, ☐ ECZEMA, ☐ EXCESSIVE SCAR TISSUE, ☐ HYPERSENSITIVITY OR SKIN 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 GROIN LYMPH NODES, ☐ SWOLLEN NECK LYMPH NODES , ☐ SWOLLEN UNDERARM LYMPH NODES.

MUSCULAR/SKELETAL: ☐ BACK PAIN, ☐ JOINT PAIN, ☐ JOINT REDNESS, ☐ JOINT SWELLING, ☐ LEG CRAMPS, ☐ MORNING STIFFNESS, ☐ MUSCLE TENDERNESS, ☐ NECK PAIN, ☐ STIFFNESS, ☐ WEAKNESS OF MUSCLES, ☐ DIFFICULTY WITH WALKING.

NEUROLOGICAL: ☐ BURNING OF TOES OR FINGERS, ☐ HYPERSENSITIVITY, ☐ NEUROLOGICAL PROBLEMS, ☐ NUMBNESS, ☐ TREMORS, ☐ PARALYSIS, ☐ RECENT SEIZURE, ☐ STOCKING/GLOVE NUMBNESS, ☐ TINGLING OF TOES OR FINGERS, ☐ 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 WITH INSPIRATION, ☐ WHEEZING, ☐ SNORING, ☐ RECENT ASTHMA ATTACK, ☐ RECENT EXPOSURE TO TUBERCULOSIS, ☐ SHORTNESS OF BREATH, ☐ SLEEP APNEA

❼ SIGNATURES

❶ 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:** _____/_____/_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

IF NOT PATIENT, RELATIONSHIP TO PATIENT: ☐ PARENT ☐POWER OF ATTORNEY ☐ LEGAL GUARDIAN

☐ OTHER: _____

❷ 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: _____**Date:** _____/_____/_____

❸ 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:** _____/_____/_____

❹ PRIVACY INFORMATION **CHECK ALL THAT APPLY**

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 E-MAIL?	☐ **Y**	☐ **N**	ON CELL VOICE MAIL?	☐ **Y**	☐ **N**

OTHER INSTRUCTIONS ON MEDICAL INFORMATION HANDLING_____

SIGNATURE: _____**Date:** _____/_____/_____

❺ 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:** _____/_____/_____

❻ ACKNOWLEDGEMENT OF RECEIPTS 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 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) NOTICE OF PRIVACY PRACTICES, A COPY IS AVAILABLE IN OUR OFFICE FOR YOUR REVIEW AND TO TAKE HOME.

❼ 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.