All Valley Podiatric Group
Foot and Ankle Specialists
Anoosh Moadab, DPM and Kathryne F. Rupley, DPM
The Next Generation of Comprehensive Podiatry

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Phone: 559-436-1213 Fax: 559-436-4202
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First Name: ________________________ Middle Initial: _______ Last Name: ___________________________________
Gender: ☐Female ☐ Male

Social Security #: ______-______-______ Birthdate: _____/_____/_______ Age: _____ E-Mail: ______________________

Street Address: ____ City: _________________ State: _____ Zip: _______

Home Phone: (______) ______-________ Work Phone: (______) ______-_________ Cell Phone: (______) _____-________

Primary Physician: _______________________________________ Date Last Seen by Primary Physician: ____/____/______

Referring Physician: ______________________________________ Primary Language: ☐ English ☐ Other: _____________

Race: ☐American Indian / Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian / Pacific islander ☐White
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Emergency Contact Person: _____________________________________ Emergency Phone: (______) _______-_________

How did you find out about us: ☐Insurance Company ☐Internet Search ☐Yellow Pages ☐Radio ☐TV ☐Other Patient or Friend

Did your Doctor Refer you to us? Doctor's name: ____________________________________ Your Shoe Size: ___________

What is your Occupation: ________________________ **What is the reason for today's visit?** ________________________

Do you have **Allergies** to Drugs or Medication: (Please list): ____

What Are your Current **Medications**? (Please list): ____

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What are your **Current Medical Illnesses**? ☐ Heart Disease ☐ High Blood Pressure ☐ Heart Murmur ☐ Chest pain ☐ Heart Attack ☐ Atrial Fibrillation ☐ Blood Clots ☐ Lung Disease ☐ Bronchitis ☐ Emphysema ☐ Asthma ☐ Persistent Cough ☐ Shortness of Breath ☐ Wheezing ☐ Stomach Ulcer ☐ Acid Reflux ☐ Nausea ☐ Diarrhea ☐ Liver Disease ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Sciatica ☐ Back Injury ☐ Blood Clots in Legs ☐ Leg Swelling ☐ Bleeding Disorder ☐ Take Aspirin ☐ Take Coumadin ☐ Anemia ☐ Diabetes ☐ Hypothyroid ☐ Weight Change ☐ Calf Pain with Walking ☐ Fever or Chills ☐ Other:

____

Do you **Smoke**? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No How much and for how long? _____________________
Do you drink **Alcohol**? ☐ Yes ☐ No How often do you drink? ☐ Daily ☐ Occasionally ☐ Only Socially

Notice of Privacy Practices: The Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) are federal programs that require that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. We may use and disclose your health information for the purpose of treatment, payment, health care operations, and patient contact. You may request to inspect, copy, and / or amend your protected health information.

HIPAA Acknowledgement: I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Assignment of Payment Benefits: I hereby authorize payment directly to above named physicians of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

Release of Information: I hereby give consent to release to authorized persons financial and medical information concerning care, treatment, and charges therefore, as may be required to complete all claims for benefits.

Financial Responsibility: Guarantor is responsible for all charges regardless of insurance payment.

Signature: ____ Date: _____________________