Robert Anavian, D.P.M 23456 Hawthorne Blvd. Suite 270 Torrance, CA 90505 (310) 375-1417

PATIENT INFORMATION								
Date:								
Social Security #:								
Patient Last Name:								
First Name: MI:								
Address:								
City: State: Zip:								
E-mail:								
Sex: M F Age: Birthdate:								
□ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered								
Patient Employer/School:								
Employer/School Address:								
Employer/School Phone: ()								
Spouse's Name:								
Birthdate: SS#:								
Spouse's Employer:								
Whom may we thank for referring you?								
PHONE NUMBERS								
Home Phone: ()								
Cell Phone: ()								
Best time and place to call:								
In Case of Emergency, Contact								
Name:								
Relationship:								
Home Phone: ()								
Cell Phone: ()								

INSURANCE
Who is responsible for this account?
Relationship to Patient:
Insurance Co.:
Group #:
Pt. covered by additional Insurance: ☐ Yes ☐ No
Subscriber's Name:
Birthdate: SS#:
Relationship to Patient:
Insurance Co.:
Group #:
INSURANCE ASSIGNMENT AND RELEASE
I certify that I have insurance coverage with:
Name of Insurance Company(ies) and assign directly to Dr. Robert Anavian, DPM all insurance benefit fany, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid to insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and r disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining paymen for services and determining insurance benefits or the benefits payar for related services. This consent will end when my current treatme plan is completed or one year from date signed below.
MEDICARE/MEDIGAP AUTHORIZATION
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made on my behalf to Dr. Robert Anavian, DPM for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare a Medicaid Services, my Medigap insurer, and their agents any
information needed to determine these benefits or benefits for relate services.

Relationship to Beneficiary

Date

PODIATRIC HISTORY									
What is the chief complate treated? (Include foot, a complaints.)			Athletic Activitie indicate frequen	s you participate in (please locy):	list and				
		· · · · · · · · · · · · · · · · · · ·							
Have you ever been to a If yes, Please list.	a Podiatrist befo	re? □ Yes □ No	have had in the	which foot problems you no past.	w have of				
News			□ Ankle Pain						
Name:			☐ Athlete's foot						
Last Visit:			☐ Bunions						
Luct viol.			□ Corns and Calluses□ Numbness in feet, legs						
Is there any personal or family history of diabetes?			□ Flat Feet						
☐ Yes ☐ No Explain:			□ Foot or Leg Cramps						
			□ Heel Pain						
Cigarette/Tobacco use:			□ Ingrown Nails						
			□ Plantar Warts□ Swelling of Ankles or Feet						
Years Smoked:			☐ Tired Feet						
Your Occupation:			- 1.1.5d 1.5dt						
MEDICAL HISTORY									
			<u> </u>						
Please check any condit	ion you have cu	rrently or in the past:		I					
AIDS/HIV	□ Yes □ No	Ear Problems	□Yes □No	Radiation treatment	□Yes □No				
Anesthetic Allergies	☐ Yes ☐ No	Epilepsy	□Yes □No	Rash	□Yes □No				
Medicine Allergies	☐ Yes ☐ No	Eye Problems	□Yes □No	Respiratory Disease	□Yes □No				
Anemia	□ Yes □ No	Fainting	□Yes □No	Rheumatic Fever	□Yes □No				
Angina	☐ Yes ☐ No	Foot or Leg Cramps	□Yes □No	Shortness of breath	□Yes □No				
Arthritis	☐ Yes ☐ No	Gout	□Yes □No	Sinus Problems	□Yes □No				
Artificial Heart Valves	☐ Yes ☐ No	Headaches	□Yes □No	Special Diet	□Yes □No				
Artificial Joints	☐ Yes ☐ No	Heart Disease	□Yes □No	Stroke	□Yes □No				
Asthma	☐ Yes ☐ No	Hemophilia	□Yes □No	Swelling in Ankles	□Yes □No				
Back Problems	☐ Yes ☐ No	Hepatitis or Jaundice	□Yes □No	Swollen Neck Glands	□Yes □No				
Bleeding Disorders Cancer	☐ Yes ☐ No	High Blood Pressure	□Yes □No □Yes □No	Tired Feet	□Yes □No □Yes □No				
Chemical Dependency	□ Yes □ No □ Yes □ No	Kidney Problems Liver Disease	□Yes □No	Tuberculosis Ulcers	□Yes □No				
Chest Pain	☐ Yes ☐ No	Low Blood Pressure	□Yes □No	Varicose Veins	□Yes □No				
Chronic Diarrhea	☐ Yes ☐ No	Neuropathy	□Yes □No	Venereal Disease	□Yes □No				
Circulatory Problems	□ Yes □ No	Phlebitis	□Yes □No	Weight loss, unexplained					
Diabetes	□ Yes □ No	Psychiatric Care	□Yes □No	and the second s					

Surgeries you have ha	ad:							
Hospitalizations other	than for the surgeries listed:							
•	you been under any other doctor	•	•	•				
MEDICATIONS Include prescriptions, over the counter medications and vitamins:								
include prescriptions,	over the counter medications an	d vitamins:						
			macy Phone: ()				
	aceptives? □ Yes □ No							
		ALLERGIES						
· · · · · · · · · · · · · · · · · · ·	□ Anticoagulant Therapy	□ Aspirin	□ Codeine	☐ Demerol	□ lodine			
☐ Local Anesthetics Please list any other A	□ Novocain □ Penicillin Illergies you may have:	□ Seafoods	□ Sulfa					
T lease list arry other F	mergies you may have.							
TREATMENT CONSENT								
	give permission to Robert Anavia n such procedures upon me as t			ants or designate	ed replacement) to			
Signature of Patient, F	Parent, Guardian or Personal Re	presentative		Date				
Please print name of F	Patient, Parent, Guardian or Pers	sonal Represent	ative	Relationship	to Patient			