ALLEN MASSIHI, D.P.M

Disease, Injuries, & Surgeries of Foot/Ankle

PATIENT REGISTRATION

Patient Name:_____ Date of Birth ___/___/___

Please Circle: Married Single Widowed Divorced Separated Sex: Male Female

Home Address:_____

City:_____ State:_____ Zip Code_____

Home Phone: (818)_____ Social Security #:_____

Cell Phone: (____)_____ Business Phone: (____) _____

Occupation:_____

Business Address:_____

Name of Spouse:_____ Occupation:_____

Person to be notified in case of emergency: _____

Relationship:_____ Phones #: (____)_____

INSURANCE INFORMATION: __ WORKCOMP ☑ PPO ☑ HMO

AUTHORIZATION #:_____

Primary Ins._____ Secondary Ins._____

Insured (circle one) self spouse parent other Insured (circle one) self spouse parent other

Whom may we thank for referring you?_____

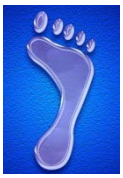
Are you sensitive or allergic to any Medications? ☑ YES ☑ NO

If yes, list:_____

I request that payment of authorization benefits be made to **Dr. Massihi** for any services furnished. I authorize any holder of medical information about me to release to my insurance company for any information needed to determine these benefits or the benefits payable to related services.
I understand that when notified by a physician/supplier that Medicare may deny payment for certain services, I am agreeing to be personally and fully responsible for payment. I authorize the physician/ supplier to treat me for medical conditions.

_____ _____

Patient Signature Date



DR. ALLEN MASSIHI, D.P.M.

Diseases, Injuries & Surgeries of Foot/Ankle

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit:_____

_____

Present medication: _____

Allergies to medication/other: _____

Primary care physician:_____

Previous or other medical problems:_____

Previous surgeries or hospitalizations: _____

Previous motor vehicle accidents: _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you regularly drink alcohol ☐ Yes ☐ No

PAST MEDICAL INFORMATION (CHECK ALL THAT APPLY)

☐ Migraine/Headache	☐ Chest Pain/Pressure/Tightening	☐ Osteoarthritis
☐ Depression	☐ Hypertension	☐ Gout
☐ Dizzy Spells	☐ Heart Attack	☐ Anemia
☐ Memory Loss	☐ Coronary Artery Disease	☐ HIV/AIDS
☐ Diabetes	☐ Pacemaker	☐ Kidney Disease
☐ Glaucoma	☐ Ulcer	☐ Urinary Infection
☐ Thyroid Disease	☐ Hepatitis	☐ Seizures
☐ High Cholesterol	☐ Blood in Stool	☐ Neurological Disease
☐ Asthma	☐ Liver Disease	☐ Stroke
☐ TB/Lung Disease	☐ Gallbladder Disease	☐ Cancer
☐ Shortness of Breath	☐ Rheumatoid Arthritis	☐ Skin Disorder

Form filled out by:_____

ACKNOWLEDGE OF RECEOPT OF NOTICE OF PRIVACY PRACTICES
&
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEAKT CARE OPERATIONS

I hereby acknowledge that I understand and have been provided with a copy of Allen Massihi, Inc.'s Notice of Privacy Practice. I further acknowledge that I have been informed that a copy of the current notice is posted in the reception area.

I understand that this medical practice reserves the right to change their notice of Privacy Practices and that any change, identified by its "effective date", will be posted in the reception area.

I will be sure to request a copy of the most current (amended or revised) Notice on my first visit following the effective date

I consent to the use and disclosure of my protected health information to carry out treatment, payment, or health care operations.

Effective date of notice: 04/14/2003

_____ _____
Signature of Patient or patient's representative Date

_____ _____
Printed Name of Patients or patient's representative Date

Office Use Only_____

Reason acknowledgement was not obtained: _____
_____

****

Effective date of notice:_____

_____ _____
Signature of Patient or patient's representative Date

_____ _____
Printed Name of Patients or patient's representative Relationship to patient, or representative
Authority to act for patient, if applicable

Office Use Only_____
Reason acknowledgement was not obtained:_____
_____