Welcome to Our Office

Drs. Sabet & Yetter
31852 Coast Hwy., Suite 105, Laguna Beach, CA 92651
(949) 499-4534

Patient Information

Last Name ________________________ First Name _________________________ Initial _______________

Name You Go By _________________ Age _______ Date of Birth _____/_____/____ Sex: M F

Street_________________________________ City________________________ State _______ Zip________

Home Phone ( ) ______________ Cell Phone ( ) ________________ Work Phone ( ) _____________

Social Security # _______________Driver's License # ______________ Marital Status: M S W D

Employer _____________________________________ Occupation __________________________________

Street___________________________________ City_________________________ State _____ Zip ______

Emergency Contact_________________________ Relationship ________________ Phone: _______________

Referring Information

Who may we thank for referring you? ____

Family Doctor _____________________________Previous Podiatrist_________________________________

Insured Person or Subscriber (if other than above)

Last Name ____________________________ First Name ________________________ Initial ____________

Date of Birth _____/_____/____ Age____________ Sex: M F

Home Phone ( ) ______________ Cell Phone ( ) _______________ Business Phone ( ) ___________

Social Security # _______________________Driver's License # ____________________

Employer ___________________________________ Occupation __________________________________

Street___________________________________ City_________________________ State _____ Zip ______

Insurance Information

Primary Insurance____ Group # __________________

ID#____

Eligibility Waiver

I authorize my insurance company to pay any and all charges rendered on my behalf directly to Drs. Sabet and Yetter. I will be responsible for and will guarantee payment on any and all charges which may not be paid or covered by my insurance company. I certify that the information given, including insurance coverage is complete and correct. **I understand I will be charged $50 for a missed appointment without 24 hours' notice.**

Signature: ________________________________ Date: _____________________

Email: ___________________________________Your email address will never be shared without your permission

Medical History

What is your foot problem? ____

____

When did problem begin? ______________________ Date (if an injury): ______________________

Describe any accident/event ____

Previous X-rays? Yes No Previous MRI? Yes No Previous CT? Yes No

Describe any previous treatment or home remedies ____

Have you ever had foot surgery? Yes When and by whom? ______________________________

Are you here for a: Consultation Surgical Evaluation Second Opinion Workers Comp Evaluation

Do you have or have you ever been treated for:

Diabetes I or II	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Poor Circulation	Yes	No
Problems Healing	Yes	No
Kidney Disease	Yes	No
Asthma	Yes	No
Autoimmune Disease	Yes	No
Sleep Apnea	Yes	No
HIV	Yes	No

List other health problems: ____________________

____

Height: _____________ Weight: ________________

How much are you on your feet at work?

20% 40% 60% 80% 100%

Do you smoke? No Yes packs per day ____

Do you drink alcoholic beverages?

None Rarely Moderately Daily Quit

List any sports/activities: ______________________

If female, are you pregnant? Yes No

Allergies to Medications or Materials:

Antibiotics (please list below)	Yes	No
Pain Meds (Codeine, Vicodin)	Yes	No
Local anesthetics	Yes	No
Adhesive tape	Yes	No
Latex	Yes	No
Iodine	Yes	No

Type of reaction: ____________________________

Any Other Allergies: __________________________

Do you take any of the following medications?

	Yes	No	Medication
Insulin			______________
Diabetic medication			______________
Blood thinner			______________
Heart medication			______________
Water pills			______________
Birth control pills			______________
Anti-depressant			______________

Please list other medications: ________________

____

____

____

Please list previous medical or surgical problems: ____

____

Your Name: ____________________________________

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Privacy Practices and Consent

The Health Insurance Portability & Accountability Act of 1996 requires that all medical records and other individually identifiable health information used or disclosed by this office be kept properly confidential. The individual is also provided the right to request confidential communications or that a communication of protected health information (PHI) be made by alternative means.

I wish to be contacted in the following manner (circle all that apply):

1. Home Telephone ____________________________
   a. OK to leave message with spouse
   b. OK to leave message with detailed information
   c. Leave message to call the office only
2. Work Telephone_______________________________
   a. OK to leave message with detailed information
   b. Leave message to call the office only
3. Written Communication
   a. OK to mail to my home address
   b. OK to mail to my work or office address
   c. OK to fax to this number ____________________________
   d. OK to exchange information with referring doctors and treatment facilities
4. Other ___________________________________

____ __________________________
Patient or Guardian Signature Date

____ __________________________
Print Name Birth Date

I authorize your office to disclose my health information to the following people if needed

1. ____

2. ____