(Dr. Java) 8737 Beverly Blvd. # 103 Los Angeles, CA 90048 Date:

Last Name: _____ **First Name:** _____ **Date of Birth:** _____

Street Address: _____ **Apt. #** _____
City: _____ **State:** _____ **Zip Code:** _____

Home phone # ( ) _____ **Mobile # ( )** _____

Emergency Contact ( ) _____ **Relationship:** _____

Email Address: _____

Weight:	**Height:**	**Shoe Size:**
Gender: **M** ○ **F** ○	**Marital status:**	**Occupation:**

How did you hear about us? **Doctor Referral** ○ **Insurance** ○ **Friend/Family** ○ **Internet/Google** ○
Referred by: _____ **Other:** _____

****Reason** **for today's visit and** **duration** **of problem:** _____

_____

Any foot problems you now have or had in the past: Ankle Pain ☐ **Bunion** ☐ **Heel Pain** ☐
Flat Feet ☐ **Hammertoe** ☐ **Wart** ☐ **Ingrown Toenail** ☐ **Athlete's Foot** ☐
Fungal Toenail ☐ **Corn / calluses** ☐ **Foot Fracture** ☐ **Poor Circulation** ☐

Insurance: Primary Secondary Cash ☐ **Workers Comp** ☐ **PI** ☐

Cigarette / Tobacco use: No ○ **Yes** ○ **Duration ( ) Alcohol: No** ○ **Yes** ○

Do you have, or have you had any of the following? Check the box.

Diabetes Insulin Oral ☐ **How long:**	**Wart** ☐
Chest Pain / Angina ☐	**Kidney Problems** ☐ **Dialysis** ☐
High Blood Pressure ☐	**Cancer** ☐ **If yes, what type ( )**
Heart Disease ☐ **Circulatory problem** ☐	**Asthma** ☐
Pacemaker / Metal Implants ☐	**Rheumatoid Arthritis** ☐
Gout ☐	**Liver / Hepatitis** ☐
Stroke ☐	**Tested Positive for HIV** ☐
Numbness/ Neuropathy ☐	**Thyroid problem** ☐
Cholesterol ☐	**Depression** ☐ **Bipolar** ☐

Any family history of diabetes? No ○ **Yes** ○ **Who ( )**

Any family history of cancer No ○ **Yes** ○ **Type ( ) Who ( )**

Allergies: Not known ☐ **Aspirin** ☐ **Codeine** ☐ **Penicillin** ☐ **Sulfa** ☐ **Iodine** ☐
Seafood ☐ **Tape** ☐ **Latex** ☐ **Local anesthetic** ☐ **Others ( )**

Surgeries:
Have you ever been to a podiatrist before: No ○ **Yes** ○ **Name ( )**

Medications / Dosage

1-	**4-**	**7-**
2-	**5-**	**8-**
3-	**6-**	**9-**

(Dr. Java) 8737 Beverly Blvd. # 103 Los Angeles, CA 90048 Date:

Last Name: _____ First Name: _____ DOB: _____

I certify that I have insurance with the above company and assign directly to Dr. Java.
All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above company(ies) for purpose of obtaining payments

SIGNATURE:_____DATE:_____

PRIVACY AGREEMENT

I have received this practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made. By this practice, my individual rights and the practiced legal duties with respect to my protected health information. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

SIGNATURE:_____DATE:_____

PRIMARY PHYSICIAN:_____

TREATMENT AUTHORIZATION AND FINANCIAL AGREEMENT

I authorize Dr. Java to provide treatment and certify to be financially responsible for these services. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I authorize Dr. Java to apply for benefits on my behalf for all covered services rendered. I request that payment from my insurance company can be made directly to the doctor.

I certify that the information that I have reported with regard to my insurance coverage is correct. If I am not covered by my insurance at any time, I understand that I am financially responsible for services rendered. I understand that I am responsible for any amount not covered by my insurance.

There are **no refunds** for services, treatments, procedures, shots, packages, products.

I agree to settle any account balances over 90 days old and I agree that payments will not be delayed or withheld regardless of treatment, outcome, lawsuits, or is insurance benefits and coverage.
I permit a copy of this authorization be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

SIGNATURE:_____DATE:_____