Pahrump Podiatry / 2080 East Calvada Blvd / Pahrump, NV 89048
Phone: 775-751-5200 / Fax: 775-582-1307

Patient Demographics

Date of Birth:_____ SSN:_____

Full Name:_____ Gender: ☐M ☐F ☐0ther
First Middle Initial Last

Address:_____
Unit #

_____
City State Zip

Phone Number:_____ _____
Primary Secondary

Marital Status:☐Married ☐Single ☐Other Email Address:_____

Emergency Contact:_____ Number:_____

Employer Name/Occupation:_____

Referred by:_____ Preferred Pharmacy:_____

Primary Physician:_____ Number:_____

Insurance

Primary Insurance:_____

ID#:_____ Group:_____

Insurance Address: _____Guarantor's D.O.B.:_____

Secondary Insurance:_____

ID #:_____ Group #:_____

Insurance Address:_____ Guarantor's D.O.B._____

Medical History

Are you currently under your physicians' care? If yes, for what reason?
Name of Doctor: _____
_____
_____

Have you has previous treatment by a podiatrist? If yes, for what reason?
_____
_____

What is your chief complaint for seeing the podiatrist today?
_____
_____

Do you have any allergies? Please include prescription medication, over the counter medicines, adhesives, tape, food, seasonal, etc...
_____
_____

Please list all medications you are currently taking:

_____
_____

Please list any herbal or dietary supplements you are currently taking.
_____

Are you pregnant? If so, what is your expectant due date?
_____

Please list all surgeries you have had in the past:
_____
_____

Have you ever been hospitalized? If so, please list dates and reason.
_____
_____

Is there anything else you would like to mention about your visit today?
_____
_____

Patient Information & Health History

My chief foot complaint is: _____

How long has the condition existed? _____

Symptoms: _____

Which Side: Right _____ Left____ Both_____

Type of Pain: Dull____ Achy____ Throbbing____ Sharp____ Burning____ Shooting____

Area of Pain: _____

Since your pain began, has it gotten: Better____ Worse____ Stayed the same____

What aggravates your condition? Walking ____ Running _____ Standing _____ Wearing Shoes_____

What have you tried to help the pain? New shoes_____ Anti-Inflammatory_____
Decrease in activities_____ Ice_____ Arch Supports_____ Orthotics_____ Stretches_____
Other_____

Onset of Pain: Slow_____ Sudden_____ Traumatic_____

Weight: _____ Height: _____ Shoe Size: _____

Do you smoke tobacco? Yes____ No____

Smoking duration: ___ Days___ Weeks ____Years Packs: ____Day _____Week

Do you drink alcohol: Yes____ No_____
If so, how many days/drinks per week: Days_____ Avg # of Drinks _____

Recreational Drugs: Yes____ No____
If so, what type? _____

Please mark YES or NO to indicate if you or a family member has had the following:

	PERSONAL		FAMILY	
Alcoholism	Yes	No	Yes	No
Anenia	Yes	No	Yes	No
Arthritis: Type: _____	Yes	No	Yes	No
Artificial Heart Valve/Joints: Type _____	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Back Problems	Yes	No	Yes	No
Bleed Easily	Yes	No	Yes	No
Cancer: Type_____	Yes	No	Yes	No
Chemical Dependency	Yes	No	Yes	No
Chest Pain	Yes	No	Yes	No
Circulatory Problems	Yes	No	Yes	No
Depression	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Eating Disorder	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No
Fibromyalgia	Yes	No	Yes	No
Gout	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
Hemophilia	Yes	No	Yes	No
Hepatitis	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
HIV Positive	Yes	No	Yes	No
Kidney Problems	Yes	No	Yes	No
Leg Cramps	Yes	No	Yes	No
Liver Disease	Yes	No	Yes	No
Lung Respiratory	Yes	No	Yes	No
Menopause	Yes	No	Yes	No
Mental Illness	Yes	No	Yes	No
Psychiatric	Yes	No	Yes	No
Phlebitis/Clots	Yes	No	Yes	No
Psoriasis	Yes	No	Yes	No
Rheumatic Fever	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Thyroid Problems	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No
Ulcers-Stomach	Yes	No	Yes	No
Venereal Disease	Yes	No	Yes	No
Weight Change	Yes	No	Yes	No

Authorization for Treatment and Financial Agreement

I hereby consent to and authorize all treatment that may be necessary to and advisable by Dr. Bobby Pourziaee and his staff. I understand that no guarantee or assurance has been made as to the results that may be obtained. I understand that charges will be made for the office visit and other procedures such as x-rays, laboratory examinations, etc... and hereby agree that I am financially responsible for any charges not covered by my health care plan. I hereby authorize the Doctor to release all information necessary to secure the payments of health care benefits.

Patient Name:_____

Patient Signature: _____

Date:_____

Parent/Guardian Name & Signature (if applicable):
_____

Date:_____

Cancellation Policy

A **$35.00 Cancellation fee** will be applied to appointments not cancelled within 24 hours. This fee pertains to ALL appointments.

Patient Name:_____

Patient Signature: _____

Date:_____

Parent/Guardian Name & Signature (if applicable):
_____

Date:_____

Acknowledgement of receipt of Notice of Privacy Practice

I acknowledge that I was provided a copy of the Notice of Privacy Practices by Dr. Bobby Pourziaee, D.P.M. and that I have read, or had the opportunity to read if I so choose and understand the Notice.

Patient Name:_____

Patient Signature: _____

Date:_____

Parent/Guardian Name & Signature (if applicable):
_____

Date:_____

PATIENT AUTHORIZATION FOR PHOTO OR VIDEO

I, _____, authorize Pahrump Podiatry to photograph or video record my foot, ankle or leg region to use such materials in its sole discretion and in any manner including, but not limited to; tracking medical progress, social media use, informing the public about services provided, the circumstances surrounding same and the medical care and treatment that I have been receiving and/or will receive in the future. I understand and acknowledge that any photograph, videotape or printed or published materials could be reproduced by unknown persons or organizations and republished via internet or other media without my knowledge or consent. Pahrump Podiatry has made no representations, promises or assurances to me about potential use of any materials and I have not relied on any statements by any representatives of Pahrump Podiatry in deciding to participate. I waive any claims against Pahrump Podiatry for any compensation for use of any such materials and waive any claims against Pahrump Podiatry relating to use, publication or broadcast of any materials.

Further, I authorize Pahrump Podiatry and/or its subsidiaries, partnerships, limited partners, general partners, parent companies or affiliates, including but not limited to Bobby Pourziaee DPM, Inc. to hereby waive any right to compensation for Pahrump Podiatry's use such materials which may display my likeness, photographs, image, voice, statements and name and release Pahrump Podiatry and its employees and agents, including any physicians or other health care providers, from liability for any causes of action or claims of damages relating to Pahrump Podiatry's use of such materials including, but not limited to any claims of invasion of privacy, defamation, infringement of my right of publicity or copyright infringement.

Patient Name:_____

Patient Signature: _____

Date:_____

Parent/Guardian Name & Signature (if applicable):

_____

Date:_____