Mitra Tabassian, D.P.M.

994 S La Brea Inglewood CA 90301

PATIENT INFORMATION

Patient Name_____ Date Of Birth_____ SS#:_____

Home Address _____

City_____ State_____ ZIP_____

Home Phone _____Cell #_____ Work #_____

Height _____Weight: _____Shoe Size:_____ Have you worn orthotics? Y N

Employer_____ Occupation_____

Emergency Contact_____Phone_____

Spouse's Name_____ Date of Birth_____ SS#_____

Primary Care/Family Physician:

Name _____ City_____ State_____

Who May We Thank For Referring You To Our Office_____

PRIMARY INSURANCE INFORMATION

Primary Insurance:_____ Group #:_____

Member ID #:_____Copay$:_____

Name of Policyholder:_____ Relation to Patient:_____

If different than patient:

Policyholder address:_____

(Street) (City) (State, Zip Code)

Policy Holder's: Date of Birth:_____ SS#:_____

SECONDARY INSURANCE INFORMATION

Secondary Insurance:_____

Member ID #:_____ Co-pay$_____

Name of Policyholder_____ Relationship:_____

If different than patient:
Policyholder address_____
(Street) (City) (State, Zip Code)

Policy Holder's: Date of Birth _____SS#:_____

CURRENT PROBLEM:

What is your present foot problem_____

How long have you been bothered by the above?_____

What have you done for the above problem?_____

_____

PAST MEDICAL HISTORY:

Are you now, or have you been under a physician's care during the past two years? Yes No

Date of your last physical exam:_____ Any recent hospitalizations? Yes No

Are you currently taking any medications? Yes No

If Yes, what medications (PLEASE LIST)_____

_____

Circle if you <u>have or were treated</u> for the following (circle all that apply):

AIDS	Bleeding tendency	Heart disease	Mitral Valve Prolapse
Allergies	Cancer	Heart Murmur	Nervous Condition
Anemia	Diabetes	Hepatitis	Rheumatic Fever
Epilepsy	High blood pressure	Blood clots	Sciatica
Arthritis	Glaucoma	Kidney disease	Ulcers
Asthma	Gout	Liver trouble	Numbness in feet or legs
Alcoholism	Swelling	Shortness of breath	Chest Pain
Stroke	Depression	Low back pain	Leg Cramps

Other:_____

MEDICATION ALLERGIES: Yes____ No____ (Please List And Explain What Occurred)

_____

Previous Surgeries (Please List):_____

Do you smoke? Yes No

Drink Alcohol? Yes No If yes, how often? Daily Weekly Monthly

Vitamins, supplements, etc:_____

FAMILY HISTORY:

Circle if any blood relatives have had:

Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease

Any other pertinent information I should know?_____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient (Please Print) _____

I request that all communications to me (by telephone, mail or otherwise)
by Dr. Mitra Tabassian and/or his staff be handled in the following manner:
For written communications, address to:

_____

_____

_____

For oral communications, telephone number(s) we can call:

1._____

2._____

May we leave a phone message? Yes____ No_____

May we leave a message with any person? Yes____ No____

If no, may we leave a message with specific person(s)? Yes____ No____

Relationship(s):_____

Financial Policy for Mitra Tabassian, D.P.M.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skilled and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

CO-PAYS: Are due at the time of service.

SELF PAY: Payment is due in full at the time of service if you do not have health insurance.

MEDICARE: We are a participating Medicare provider. Medicare and your secondary insurance will be billed for you. You are responsible for your co-pay or any deductible amounts.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment and/or explanation of benefits is received from your primary insurance company.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist, you may need to have a referral from your primary care physician prior to seeking care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of the visit. If a referral is not provided **you are** fully responsible for all services provided if denied by the insurance company.

PATIENT BILLING: You will be sent up to three notices for you financial responsibility. After the third and last notice, your account will be forwarded to collections.

I have read the above policy regarding my financial responsibility to Mitra Tabassian, D.P.M. for providing medical services to me or the below named patient. I agree to pay Mitra Tabassian, D.P.M. for any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health insurance coverage.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Mitra Tabassian, D.P.M. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Patient Name (Please Print):_____

Other Responsible Party_____ Relationship to patient _____

Signature_____Date_____