AL GHAMGOSAR, D.P.M.

Foot & Ankle Surgery • Trauma • Reconstruction

Fellow, American College of Foot & Ankle Surgeons
Diplomat, American Board of Podiatric Surgery

FIRST:_____ MI:_____ LAST:_____

DATE OF BIRTH: _____ MALE/FEMALE SSN#:_____

HOME ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK:_____ CELL:_____

PLACE OF EMPLOYMENT: _____

SPOUSE OR GURANTOR:_____

ADDRESS:_____

PRIMARY PHYSICIAN: _____ PHONE#: _____

WHO CAN WE THANK FOR REFERRING YOU: _____

EMERGENCY CONTACT: _____ PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID#: _____

SUBSCRIBER: _____ GROUP #: _____

DATE OF BIRTH:_____

I hearby give permission to Dr. Ghamgosar's office to examine and treat my feet and/or ankles. I authorize my insurance benefits to be paid directly to Dr. Ghamgosar's office. I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance on my account for all services rendered by the Peninsula Foot & Ankle Center.

Signature:_____ Date:_____

Peninsula Foot & Ankle Center
50 S. San Mateo Drive, Ste. 150 San Mateo, CA 94401
Ph (650) 242 1689 Fx (650) 477-2162
www.PenFoot.com

AL GHAMGOSAR, D.P.M.

Foot & Ankle Surgery • Trauma • Reconstruction

Fellow, American College of Foot & Ankle Surgeons
Diplomat, American Board of Podiatric Surgery

Health History

Patient Name:_____ Age:_____

Height:_____ Weight:_____ Shoe Size:_____

Name of Primary Care Physician:_____ Date last seen:_____

What foot or ankle problems are you having? _____

_____

When did this start?_____ Due to an injury? Yes No Workers Comp? Yes No

List any prior professional care you received for this issue: _____

_____

List all medications that you currently use **or** simply give your medication list to the receptionist:

_____

List any allergies you have to medication: _____

List any surgeries you have had in the past with approximate dates: _____

_____

Do you have a family history of:
[ ] Diabetes [ ] Cancer [ ] Heart Disease [ ] High Blood Pressure [ ] Stroke

Do you smoke? Y N packs per day?_____ Do you drink alcohol? Y N drinks per day?____

Please check any condition that you have or had:

[ ] High Blood Pressure	[ ] Diabetes	[ ] Chronic Infections
[ ] Heart Disease	[ ] Hypo/Hyperthyroidism	[ ] Rheumatic Fever
[ ] High Cholesterol	[ ] Kidney Disease	[ ] Tuberculosis
[ ] Lung Problems	[ ] Liver Disease	[ ] Hepatitis
[ ] Stroke	[ ] Stomach Problems	[ ] HIV/AIDS
[ ] Seizures	[ ] Cancer: type?_____	[ ] Anxiety
		[ ] Depression

[ ] Other condition(s) not listed: _____

Who should we contact in case of an emergency?_____

Phone Number:_____ Relationship:_____

Peninsula Foot & Ankle Center
50 S. San Mateo Drive, Ste. 150 San Mateo, CA 94401
Ph (650) 242 1689 Fx (650) 477-2162
www.PenFoot.com

AL GHAMGOSAR, D.P.M.
Foot & Ankle Surgery • Trauma • Reconstruction

Fellow, American College of Foot & Ankle Surgeons
Diplomat, American Board of Podiatric Surgery

I , _____, understand that as the member of my insurance plan, I may be billed for any co-payment, deductibles, non-covered services, or any patient balance that I may incur due to services rendered at the Peninsula Foot & Ankle Center.

Please refer to your insurance card for applicable information.

Signature:_____ Date:_____

Peninsula Foot & Ankle Center
50 S. San Mateo Drive, Ste. 150 San Mateo, CA 94401
Ph (650) 242 1689 Fx (650) 477-2162
www.PenFoot.com

AL GHAMGOSAR, D.P.M.
Foot & Ankle Surgery • Trauma • Reconstruction

Fellow, American College of Foot & Ankle Surgeons
Diplomat, American Board of Podiatric Surgery

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the notice.

Printed Name: _____

Signature:_____ Date:_____

Peninsula Foot & Ankle Center
50 S. San Mateo Drive, Ste. 150 San Mateo, CA 94401
Ph (650) 242 1689 Fx (650) 477-2162
www.PenFoot.com