PATIENT REGISTRATION

TODAYS DATE_____ HOME PHONE_____

NAME_____ DATE OF BIRTH_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

WORK PHONE_____ CELLULAR/PGR_____

Email Address:_____

SOCIAL SECURITY NUMBER_____DRIVERS LICENSE NUMBER _____

EMPLOYED BY_____OCCUPATION_____

EMERGENCY CONTACT
INFORMATION_____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?_____

ADDRESS_____PHONE NUMBER_____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY(S)_____ EFFECTIVE DATE_____

NAME OF INSURED_____ COPAY AMOUNT _____

YEARLY DEDUCTIBLE AMOUNT_____ HOW MUCH HAS BEEN MET?_____

AUTHORIZATIONS

I hereby consent to and authorize the administration of all emergency, diagnostic and therapeutic treatment for me and/or my minor child that may be necessary in the judgment of Dr Nikravesh. I hereby authorize Dr. Nikravesh and any laboratories used by Dr. Nikravesh for me, to furnish information (regardless of sensitivity) to insurance carriers and I authorize and instruct these same insurance carriers to make payments directly to Dr. Nikravesh and laboratory for the medical expenses benefits. A Copy of this assignment and authorization shall be considered as effective and valid as the original. This lien is irrevocable.

I also understand that I am financially responsible to Dr. Nikravesh and laboratory for charges not covered and/or paid by my insurance carrier. If I do not pay said fees I will be responsible for all fees related to its collection. I understand **any balance over 30 days will be subject to a 10% APR interest rate and a $50 late fee** until the balance is paid in total. **Another $50** fee will be charged if sent to collection and you will be responsible for all charges related to its collection (i.e., attorney fees, court costs, etc.)

H.M.O. Disclaimer: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this admission, due to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part. **H.M.O. Patients:** if services rendered are denied due to an IPA change or non-covered services, you are responsible for the balance.

Date:_____ Signature_____(parent if minor)

MEDICAL HISTORY

TO AVOID ANY DELAY PLEASE FILL OUT **ALL** INFORMATION ☺

Name_____ Date_____

Height_____ Weight_____ Age_____ Sex_____ Shoe size_____

PRIMARY CARE PHYSICIAN

Name _____ Date of last exam _____

Address_____ Telephone _____

PAST INJURIES/SURGERIES please include APPROXIMATE DATE, PHYSICIAN/ HOSPITAL (sport & others i.e.; sprains, fractures, MVA etc.) (**THIS INFORMATION IS COMPLETELY CONFIDENTIAL**!!)
. None

_____

_____

_____

Please list all **Medications** you are currently taking . None

_____

_____

FOR **WOMEN** ONLY Are you pregnant?_____ If so, how many months?_____

ALLERGIES Please check all that apply . None

. Penicillin . Codeine . Aspirin . Tape . Sulfa . Keflex . Food(shellfish)
. Local anesthetics (xylocaine/marcaine/novacaine) . Betadine/iodine . Ibuprofen (Advil/Motrin)
. other/explain_____

PAST MEDICAL HISTORY If you have or had any of these problems please check all that apply. . None

. heart disease . rheumatoid arthritis . osteoarthritis . bleeding disorder . stroke
. heart attack(MI) . neurological disorder . seizure disorders . hypertension(high blood pressure)
. diabetes (insulin/pill/diet) . fainting . anemia . kidney diseases . hepatitis . HIV
. ulcers/stomach . circulatory disorders . high cholesterol . other/explain _____

FAMILY HISTORY (blood relative) Please check all that apply. . None
. Diabetes . bleeding disorders . genetic abnormalities . neurological disorders . other_____
. Mother . Father . Brother . Sister is Deceased Cause of death_____
. Mother . Father . Brother . Sister is Deceased Cause of death_____

Name_____ Date_____

SOCIAL HISTORY

Do you smoke? . No . Yes Number of packs per day _____ Number of years smoking _____
Do you drink? . No . Yes Drinks per day _____ Per week _____ Number of years drinking _____

Activity level . sedentary light walking . moderate light running/walking . very active athlete

REVIEW OF SYSTEMS Please check all that apply

LUNG/RESPIRATORY . None
. wheezing . coughing up blood . difficulty breathing . frequent coughing . shortness of breath
. painful breathing . bronchitis . pneumonia

CARDIOVASCULAR . None
. rapid/skipped beats . high/low blood pressure . fainting . chest pains . swollen ankles

GASTROINTESTINAL/DIGESTION . None
. loose bowels . constipation . bloating . gas . abdominal pain . Denies nausea . blood in stools
. frequent belching . hemorrhoids . heart burn . vomiting

URINARY . None
. frequent urination . pain on urination . brown/black . bloody urine . bladder infections
. unable to hold urine or a constant urge to urinate

MUSCULOSKELETAL . None
. muscle spasms or cramps . weakness in arms/legs . numbness . joint stiffness

SKIN . None
. hair loss . rashes . hives . dryness . itching . bruise easily . growth or ulcerations

NEUROLOGICAL/ HEAD . None
. headaches/migraines . ringing in ears . contact lenses . wears glasses . glaucoma
. blurry vision . seeing halos or lights . night blindness . dizziness +head injury +eye pain . cataracts

Sinus/Ear/Nose/Throat . None
. frequent colds . sore throats . sore or bleeding gums . impaired hearing . nosebleeds . hoarse voice
. sinus problems . earaches . sores on lips or tongue . difficulty swallowing . stuffiness

Endocrine . None
. cold hands and feet . gain weight easily . heat or cold intolerance . excessive thirst . excessive
. hot flashes . chronic fatigue . have lost a lot of weight recently

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

Signature: _____ Date: _____

P B NIKRAVESH DPM APC

Receipt of notice of Privacy Practices
Written Acknowledgment Form

I, _____, have received a copy of the Notice of Privacy Practices From PB NIKRAVESH DPM APC, 6404 WILSHIRE BLVD #600 , LA CA 90048.

_____ _____

Date Signature of Patient

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

X _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature (Date)

DR. NIK'S FOOT & ANKLE CENTER/ DR. P. BENJAMIN NIKRAVESH

Print or Stamp Name of Physician, Medical Group, or Association Name

By: X _____ _____

Patient's or Patient Representative's Signature (Date)

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)