Nahid Birjandi, D.P.M.

Foot and Ankle Surgery
Podiatric Medicine

Patient Consent for Use and Discloser of Protected Health Information

With your consent Dr. Nahid Birjandi may use and disclose Protected Information about you to carry out treatment, Payment and Health Care Operations. Please refer to our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 27871 Medical Center Rd. Ste. 130. Mission Viejo, CA. 92691.

_____ Initial

With your consent, Dr. Nahid Birjandi and office staff may call your home or office and leave a message in reference to any items that assist the practice in carrying out Treatment, Payment and Health Care Operations such as appointment reminders, insurance items and any call pertaining to your clinical care.

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_____ Initial

With your consent. Dr. Nahid Birjandi and office staff, may mail to your home or office any items that assist the practice in carrying out Treatment. Payment and Health Care Operations such as appointment reminder cards and patient statements.

_____ Initial

I give my consent to electronically send or fax my records for the purpose of Treatment, Payment or Health Care Operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third parry. In the event that this should occur I absolve Dr. Nahid Birjandi and office staff of all liability.

_____ Initial

By signing this form, you are consenting to our use and discloser of your Protected Health Information to carry out Treatment, Payment and Health Care Operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent.

_____ Initial

If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian _____ Date _____

This Authorization Will Remain Standing Until Revoked In Writing.

Patient's Name _____ Date of Birth _____

Print Name of Patient or Legal Guardian _____ Date _____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, _____, decline to the use and disclosure of my Protected Health Information to carry out Treatment, Payment, and Health Care Operations.

NAHID BIRJANDI, D.P.M.

Podiatry Medicine & Surgery

Welcome To Our Office

Please print and complete the following information for your case history

Last Name	First	Middle Initial	Today's Date

Spouse's Name, Parent's or Guardian's Name if a Minor	Birth Date	Age

Residence Address	City	State	Zip	Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced

Daytime Phone No.	Social Security Number	Driver's License Number and State Issued

Name of Employer	Occupation	Business Phone

Whom may we thank for referring you?	Name and phone of contact in case of emergency

List any medical conditions you have (allergies, impairments, etc.)

Name of your medical doctor	City	Are you currently under your physician's care? ☐ Yes ☐ No

If yes, for what	When did you last see your Dr.?	May we contact your physician for your health records? ☐ Yes ☐ No

Have you had previous treatment by a Podiatrist? ☐ Yes ☐ No	When	For what problem	Podiatrist's Name

My chief foot complaint is:

This condition(s) has existed for: (How Long)	Are you pregnant at this time? Yes ☐ No ☐ DNK ☐	For office use

What medicines do you take regularly? (Please list all).

Do you have or have you had any of the following: (*do not know)

	Yes	No	*DNK
Foot or Leg Injuries	☐	☐	☐
Foot or Leg Surgery	☐	☐	☐
Foot or Leg Cramps	☐	☐	☐
Foot or Leg Numbness	☐	☐	☐
Knee Pain	☐	☐	☐
Unequal Leg Length	☐	☐	☐
Weak Ankles	☐	☐	☐
Bunions	☐	☐	☐
Foot Skin Problems	☐	☐	☐
Toe Nail Problems	☐	☐	☐
Low Back Pain	☐	☐	☐
Diabetes	☐	☐	☐
Heart Trouble	☐	☐	☐
Epilepsy	☐	☐	☐
Liver Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Rheumatic Fever	☐	☐	☐
High Blood Pressure	☐	☐	☐
Polio	☐	☐	☐
Bursitis	☐	☐	☐
Stomach Ulcers	☐	☐	☐
Asthma	☐	☐	☐
Anemia	☐	☐	☐
Gout	☐	☐	☐
Fainting Spells	☐	☐	☐
Bleeder	☐	☐	☐
Blood Disease	☐	☐	☐
Circulation Problems	☐	☐	☐
Hardening of Arteries	☐	☐	☐
Varicose Veins	☐	☐	☐
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Prone to Infection	☐	☐	☐

Are you allergic to or sensitive to:

	Yes	No
Novocaine	☐	☐
Penicillin	☐	☐
Adhesive Tape	☐	☐
Materials	☐	☐
Drugs	☐	☐
Foods	☐	☐
Other (if so describe)	☐	☐

☐ Is our office allowed to send you any advertisements

Email: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL ARRANGEMENT

I hereby consent to and authorize all treatment that may be considered necessary or advisable by the physician. I understand that no guarantee or assurance has been made as to the results that may be obtained. I understand that the charges will be made for the office and x-rays and laboratory examinations, etc... and hereby agree that I am financially responsible for any such charges not covered by my health care plan.

Patient's, Parent's or Guardian's Signature-_____

Date-_____