



# David J. Soomekh, DPM

Board Certified, American Board of Foot and Ankle Surgery  
Fellow, American College of Foot and Ankle Surgeons

PH: 310.651.2366  
Fax: 310.651.2360

450 North Roxbury Dr.  
Suite 200  
Beverly Hills, CA 90210

FootAnkleSpecialtyGroup.com

## Patient Registration

### Patient Information

First Name		Middle Initial	Last Name	
Sex M F	Date of Birth	Social Security Number		Marital Status
Address		City	State	Zip
Home Phone	Mobile Phone	Email Address		
Preferred method of contact <input type="checkbox"/> Home Phone Call <input type="checkbox"/> Cell Phone Call <input type="checkbox"/> Cell Phone Text Message <input type="checkbox"/> Email Message <input type="checkbox"/> Other: _____				
Primary Care Physician		Primary Care Physician Phone		
Referred By		Referring Physician Phone		
Pharmacy Name	Pharmacy Address		Pharmacy Phone	

### Meaningful Use Information In compliance with Meaningful Use Objective (OBI-304C); by the US government, it is required to capture race, ethnicity, and language information.

Race				
<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> Black / African American	<input type="checkbox"/> White / Caucasian
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Refuse to report			
Ethnicity				
<input type="checkbox"/> Hispanic / Latino	<input type="checkbox"/> Non - Hispanic / Latino		<input type="checkbox"/> Refuse to Report / Answer	
Preferred language				
<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian	<input type="checkbox"/> Indian	<input type="checkbox"/> Other: _____

### Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relationship to Patient
------------------------	-------------------------	-------------------------

### Patient Employer / School Information

Employer/School	Occupation	Employer/School Phone		
Employer/School Address		City	State	Zip

### Billing and Insurance

Insurance Company	Insured Name	Insured Date of Birth	Relationship to Insured	
Insured Address		City	State	Zip
Secondary Insurance Name (if applicable)		Insured Name	Insured Date of Birth	



# David J. Soomekh, DPM

Board Certified, American Board of Foot and Ankle Surgery  
Fellow, American College of Foot and Ankle Surgeons

## *Patient Registration*

PH: 310.651.2366  
Fax: 310.651.2360

450 North Roxbury Dr.  
Suite 200  
Beverly Hills, CA 90210

FootAnkleSpecialtyGroup.com

## **Authorization for Use and Disclosure of Protected Health Information**

I hereby authorize David J. Soomekh, DPM to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit re-disclosure by the person or entity receiving my PHI. I voluntarily agree to this authorization, and I understand that my health care will not be affected if I do not sign this form. I hereby authorize use of my PHI for the purpose of diagnosing, treating, consulting, and referral. I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims. I acknowledge that I have read, understand, and have been offered a copy of the full HIPPA policy.

*By my signature, I acknowledge that I have read and understand the Authorization for Use and Disclosure of Protected Health Information.*

**Patient or Guardian Signature:** \_\_\_\_\_

## **Assignment of Benefits**

I hereby authorize payments to be made directly to David J. Soomekh, D.P.M. for surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for the charges not covered by this Authorization. I further agree, in the event of Non-Payment, to bear the cost of reasonable legal fees should this be required. A photocopy of this Assignment shall be considered as effective and valid as the original.

*By my signature, I acknowledge that I have read, understand and have been offered a copy of the Assignment of Benefits.*

**Patient or Guardian Signature:** \_\_\_\_\_

## **Consent for Treatment**

The information I provided is true to the best of my knowledge. I hereby give permission to the physician or his assistant(s) to initiate the diagnosis and treatment of my condition with examination, imaging studies, and/or photographs as deemed medically relevant and necessary. I also authorize the release of any previous medical records by fax, mail, electronic mail, or phone to either another treating physician or hospital as needed.

*By my signature, I acknowledge that I have read and understand the Consent for Treatment.*

**Patient or Guardian Signature:** \_\_\_\_\_

**Patient Name (please print):** \_\_\_\_\_

*Patient's Guardian (if applicable, print):* \_\_\_\_\_

**Date:** \_\_\_\_\_

# David J. Soomekh, DPM

## Medical History



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### What is the reason for your visit?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### What is the date of your injury or onset of your symptoms?

\_\_\_\_\_

### Where is the problem site?

Left  Right  Foot  Ankle  Heel  Arch

Other: \_\_\_\_\_

### Describe your symptoms:

Pain  Swelling  Numbness  Tingling  Burning  
 Dull  Sharp  Pain with Activity  Pain at Rest

Other: \_\_\_\_\_

### What previous treatments have you had? None

Orthotics  Medication  Physical Therapy

Injection  Surgery

Other: \_\_\_\_\_

### Pain Assessment

Indicate pain level on scale of 1-10, 10 being worst pain

1 2 3 4 5 6 7 8 9 10

### Current Medication(s) Please include dosage None

Medication	Dosage

### Allergies None

Latex  Penicillin  Sulfa  
 Codeine  Aspirin  Anti-Inflammatories  
 Lidocaine  Novocain  Local Anesthetic  
 Adhesive/Tape  Iodine  Seafood  
 Other: \_\_\_\_\_

### Health History

Arthritis (Type:  Rheumatoid  Osteo  Degenerative)

Diabetes ( Type I DM  Type II DM)

Cancer Type: \_\_\_\_\_

Neuropathy  Circulation Problems  Gout

Fibromyalgia  Artificial Heart valve  Asthma

Hypertension  Congestive Heart Failure  Stroke

Hypotension  Respiratory Problems  Epilepsy

Heart Problems  Kidney Dysfunction  Fainting

Low Back Pain  Liver Disease  Hepatitis

HIV/AIDS  Unexplained Weight Loss  Obesity

Other: \_\_\_\_\_

### Surgical History None

Surgical Procedure/Complications	Date

### Hospitalization None

Reason / Procedure	Date

### Family History

Father:  Alive  Deceased  Unknown

Diabetes  Hypertension  Heart Disease  Stroke

Mental Illness  Cancer: \_\_\_\_\_

Mother:  Alive  Deceased  Unknown

Diabetes  Hypertension  Heart Disease  Stroke

Mental Illness  Cancer: \_\_\_\_\_

Siblings:

Diabetes  Hypertension  Heart Disease  Stroke

Mental Illness  Cancer: \_\_\_\_\_

Continue on the back ↪

# David J. Soomekh, DPM

## Medical History



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Social History

#### Smoking

- Current Smoker     Former Smoker     Nonsmoker
- ↓
- How often do you smoke cigarettes?
- Everyday     Some days, but not everyday
- How many cigarettes a day do you smoke?
- 5 or less     6-10     11-20     21-30     31 or more
- How soon after you wake up do you smoke?
- Within 5 minutes     6-30 minutes
- 31-60 minutes     after 60 minutes
- Are you interested in quitting?
- Ready to quit     Thinking about quitting     Not ready

#### Alcohol

- Did you have a drink containing alcohol in the past year?
- Yes     No
- ↓
- How often did you have a drink containing alcohol?
- Monthly or less     2-4 times a month
- 2-3 times a week     4 or more times a week
- How many drinks did you have on a typical day of drinking?
- 1-2 drinks     3-4 drinks     5-6 drinks
- 7-9 drinks     10 or more drinks
- How often did you have 6 or more drinks in one occasion?
- Never     Less than monthly     Monthly
- Weekly     Daily or Almost Daily

#### Miscellaneous

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Date of Last Influenza Vaccination: \_\_\_\_\_

#### Women Only

Are you pregnant?     Yes     No

Are you breast feeding?     Yes     No

### Review of Systems

Please select any symptoms you have had in the past 3 months.

#### General:

- Fever     Weight Loss
- Chills     Weight Gain
- Fatigue

#### Head:

- Headache     Neck Pain
- Visual Problems     Hearing Problems

#### Endocrine:

- Hot Flashes     Heat Intolerance
- Excessive Sweating     Cold Intolerance
- Changes in Hair/Skin Textures

#### Respiratory:

- Cough     Wheezing
- Pain on Breathing     Shortness of Breath

#### Cardiovascular:

- Chest Pain     Palpitations
- Dizziness     Leg Pain when Walking

#### Gastrointestinal:

- Abdominal Pain     Heartburn
- Difficulty Swallowing     Change in Bowel Habits

#### Hematology:

- Bruising     Abnormal Bleeding
- Blood Clots     Delayed Healing

#### Urinary:

- Painful Urination     Blood in Urine
- Frequent Urination     Incontinence

#### Musculoskeletal:

- Painful Joints     Swollen Joints
- Joint Stiffness     Cramping

#### Weakness

#### Skin:

- Rash     Itching
- Wounds/Ulcers     Skin Lesion(s)

#### Neurologic:

- Tingling/Numbness     Tremor
- Seizures     Paralysis

#### Psychiatric:

- Anxiety     Depressed Mood
- Insomnia     Memory Loss

The information provided is true to the best of my knowledge

**Patient or Guardian Signature:** \_\_\_\_\_

**Patient's Name (please print):** \_\_\_\_\_

*Patient's Guardian Name (if applicable, print):* \_\_\_\_\_

**Date:** \_\_\_\_\_



# David J. Soomekh, DPM

Board Certified, American Board of Foot and Ankle Surgery  
Fellow, American College of Foot and Ankle Surgeons

*Excellence in Sports Medicine and  
Reconstructive Foot and Ankle Surgery*

PH: 310.651.2366  
Fax: 310.651.2360

450 North Roxbury Dr.  
Suite 200  
Beverly Hills, CA 90210

FootAnkleSpecialtyGroup.com

## Financial Agreement

Thank you for choosing Dr. David J. Soomekh as one of your health care providers. We are pleased to be able to render services in the evaluation and treatment of your condition.

We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered. If you are unable to provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We will submit your claims to your insurance as a courtesy and we will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please understand that you will be financially responsible for charges that are not covered by your insurance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

If you do not have insurance, payment is due in full at the time of service.

Payment for those known patient due amounts (co-payments, deductibles, non-covered services) at the time of service. Full payment for any known outstanding balance may be due at the time of your visit. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. All other payments are expected within 30 days of receipt of our billing statement.

We are committed to providing the best diagnosis and highest quality of treatment possible for our patients. Our fees for services rendered are usual and customary for our geographic area.

If you have any questions regarding your financial account with our office, please contact our billing department during normal business hours at (847) 770-6046.

### SELF PAY

We expect full payment at the time of service unless prior arrangements have been made.

### MEDICARE

We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

### PPO

We are providers for many insurance plans but are not all plans. You are responsible for verifying that we are providers for your plan. If you are a PPO member, you are responsible for co-payments, deductibles, and co-insurance at the time of treatment. Please confirm with your insurance that we are providers covered under your plan. If there are changes to your insurance eligibility, it is your responsibility to make sure we have your new insurance information, or your services will be your responsibility. Co-payments and deductibles are determined by your plan and are not something we can negotiate.

**HOSPITAL AND SURGERY CENTER CHARGES**

In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility. Your podiatric physician with Foot & Ankle Specialty Group may be part owner or have financial interest in a surgery center where you will be having surgery.

**FINANCIAL AGREEMENT**

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check, or credit card. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed in a timely manner, to ensure that payment for services rendered. I understand that I am ultimately responsible for payment of all services.

**CREDIT CARD AUTHORIZATION**

Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance in the event of delinquency. This form will be kept confidential and only authorized staff has access to the information. If, after a first, and second statement is received with no payment made within 60 days, the balance on the account will be charged to the card on file.

I acknowledge and authorize Dr. David Soomekh to charge the credit card on file, for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within 60 days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account.

No Show / Late Cancellation Fee Our office requires that you let us know by phone or voice mail of any cancellation of an appointment 24 hours or more ahead of the appointment day and time. Failure will lead to a cancellation fee of \$50 per appointment.

**Patient or Guardian Signature:** \_\_\_\_\_

**Patient Name (please print):** \_\_\_\_\_

*Patient's Guardian (if applicable, print):* \_\_\_\_\_

**Date:** \_\_\_\_\_