Airport Podiatry Group
J. Scott Rosenthal, DPM, FACFAS
David J. Liss, DPM, CWSP
9100 S. Sepulveda Blvd #100
Los Angeles, Ca 90045

Medical History

Please describe your foot and/or ankle problems:

_____

_____

Primary care Doctor: _____Phone#_____

PHARMACY NAME_____ **PHONE #**_____
PHARMACY ADDRESS_____

Allergies to medications: _____
Please list current medications: _____
_____

List Previous Surgeries_____

*__Please circle__ if you have been **diagnosed** with any of the following conditions:

Arthritis conditions	Kidney Problems	Sickle Cell Disease	Nervous Problems
Asthma	Liver Problems	Thyroid Problems	Lung Problems
Bladder problems	Heart problems		
Bleeding problem	High Blood Pressure		
Diabetes	Autoimmune Diseases, specify: _____		
Epilepsy	Any other Medical Problems: _____		

*__Please circle__ if you have any of the following in your social health History:

Alcohol use (how many drinks/week?)_____ Tobacco use (packs/day?)_____
Caffeine use Illegal Drug use_____

Date of most recent hospital stay: _____Reason:_____
Date of most recent medical examination: _____Reason:_____

I certify that the above information is complete and accurate. I hereby authorize Dr. Rosenthal and/or Dr. Liss to administer treatment and to perform such minor operative procedures as deemed medically necessary in the diagnosis and/or treatment of my foot and/or ankle conditions. I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity if I so chose) and understand the notice. I consent to photography for identification, educational, and/or documental purposes.

PATIENT'S SIGNATURE_____ DATE_____
PARENT/GUARDIAN SIGNATURE (if younger than 18yrs old)

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Patient Information

Date_____

Patients Name _____

Date of Birth _____ Age_____ **MALE / FEMALE**

Social Security Number_____

Address_____ City_____ Zip_____

Home #_____ **Cell** #_____ **Work** #_____

E-mail_____ Driver's License #_____

***Emergency Contact**_____ Relation_____

Phone #_____

Employer_____ Position_____

Employers Address_____ Employers Phone #_____

***If the patient is younger than 18 yrs. old, parent/guardian must fill out the following information:**

Parent/Guardian Name_____ Parent/Guardian SSN_____

Parent/Guardian Employer_____ Employer Phone#_____

*Who may we thank for referring you? _____ Phone #_____

*Insurance Information (please fill out subscriber information only if the patient is not the policy subscriber)

Primary Insurance _____ Member ID#_____

Subscriber_____ Date of Birth_____

Subscriber Address_____ Subscriber SSN_____

I certify that the above information is accurate and complete. I understand that I am personally responsible for payment of all the fees incurred and payment of fees is required at the time of service unless prior arrangements have been made. In the event of nonpayment, I agree to bear the cost of collection, court cost and/or legal fees. I authorize Dr. Rosenthal and/or Dr. Liss to release information for the treatment of my condition, administration of my account or submission of insurance claims. I authorize my insurance company to send payment directly to Dr. Rosenthal and/or Dr. Liss.

PATIENT'S SIGNATURE_____ Date_____
PARENT/GUARDIAN SIGNATURE (If younger than 18yrs old)