Black Warrior
Foot & Wound Center

DR. ARASH ARABI
1251 McFarland Blvd. NE
Tuscaloosa, Alabama 35406-2205
Phone # (205) 464-9619
Fax# (205) 464-9646

Personal Information

First Name _____ Last Name _____ Middle Initial _____

Date of Birth _____ Age ____ Social Security Number _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed Gender: ○ M ○ F

Street Address:

_____

_____

_____

City/Town State Zip Code

Cell Phone _____ Work Phone _____

Name of Employer _____ Occupation _____

Preferred contact: ○ Cell ○ Business May we leave detailed messages at that number?

Emergency Contact Information

Name _____ Phone Number _____ Relation to Patient _____

Billing Information (If different from above)

First Name _____ Last Name _____

Street Address _____

City/Town _____ State _____ Zip Code _____

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Insurance Information

_____ _____
Primary Insurance *(Please provide copy of card)* Identification Number

_____ _____ _____
Policy#: Group#: Effective Date:

_____ _____
Insured Name: Employer:

_____ _____ _____
Date of Birth: SS#: Relationship to patient:

_____ Plan ○ HMO ○ PPO ○ Other: _____
Secondary Insurance Name *(Please provide copy of card)*

_____ _____ _____
Policy#: Group#: Effective Date:

Is there a co-pay required for you insurance?: **Y or N** If yes, amount: _____

Is a referral required by your insurance for today's visit?: **Y or N**

_____

Name/Phone of Primary Physician: _____

Whom may we thank for referring you to our practice?_____

How did you hear about Dr. Arabi?
○ Google ○ Website ○ Facebook ○ Patient or Friend Name: _____
○ Other (please specify):

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Medical History

(Please fill out ALL sections)

All orthopedic past complaints and any pertinent family history for each category:

Foot: _____

Ankle: _____

Knee: _____

Hip: _____

Back: _____

Reason for Visit Today:_____

_____

_____

Foot Pain Specifically:

Type: _____

Duration: _____

Location: _____

Date first foot pain symptoms occurred: _____

Previous Treatment by others Physicians: _____

Past Medical/ Surgical History

Please list any **serious illnesses** (Diabetes, Blood Pressure, etc), **hospitalizations and/or operations** you have had:

_____

_____

_____

_____

_____

_____

_____

_____

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List any medications you are currently taking (prescription or non-prescription):

_____

_____

_____

_____

_____

_____

_____

_____

Current Pharmacy: _____ **Address**: _____ **Phone**: _____

Please list <u>any and all allergies</u> and describe the reaction (Omission will assume no Allergies):

_____

_____

_____

Do you drink Alcoholic Beverages? (Please list frequency): _____

_____

Do you drink Caffeinated Drinks? (Tea, Soda, Coffee, Please list frequency): _____

_____

Do you currently use any of these products? ___ Cigarettes ___ Cigars ___ Chewing Tobacco

How Often?_____

How long since you have Quit?

_____

In the Past have you had an issue with medication abuse?

_____

Do you use Illegal drugs? Including Marijuana?

_____