FOOT & ANKLE CLINICS OF ARIZONA

Please bring the following to your appointment:
- Insurance card
- Photo identification
- Medication list

Por favor traiga:
- *Tarjeta de aseguranza*
- *Identificacion*
- *Lista de medicinas*

Patient Information · *Información del paciente*

Name _____
Nombre

Patient's Social Security number _____
Número de Seguro Social del paciente

Sex ☐ Male · *Masculino*
Sexo ☐ Female · *Hembra*

Race ☐ White or Caucasian · *Blanco o Caucasico*
Raza ☐ Black or African American · *Negro o Afroamericano*
☐ Native American · *Nativo Americano*
☐ Asian · *Asiático*
☐ Hispanic or Latino · *Hispano o Latino*

Date of birth _____ Age _____
Fecha de nacimiento *Años*

Home address _____
Dirección de la casa

City _____ State _____ Zip code _____
Ciudad *Estado* *Codigo postal*

Home phone _____ Cell phone _____ Email _____
Teléfono de la casa *Teléfono celular* *Correo electrónico*

Parent or guardian guarantor's insured name _____
Nombre del asegurado del padre o tutor

Guardian's Social Security number _____
Número de Seguro Social del guardian

Preferred pharmacy _____ Crossroads _____
Farmacia preferida *Encrucijada*

Primary care physician _____ Date of last visit _____
Proveedor de atención primaria *Ultima fecha de visita*

Height _____ Feet · *Pies* _____ Inches · *Pulgadas*
Altura

Weight _____ Lbs. · *Libras*
Peso

Reason for today's visit _____
Motivo de la visita de hoy

How long have you had these symptoms? _____
¿Desde cuando ha sufrido del estos síntomas?

Have you treated the pain in any way? ·
¿Ha tratado el dolor de alguna manera?

☐ Medication · *Medicación*
☐ Changed shoe type or size · *Tipo o tamaño de calzado cambiado*
☐ Stretching · *Extensión*
☐ Other · *Otra* _____

How would you describe the pain? ·
¿Cómo describirías el dolor?

☐ Deep aching · *Dolor profundo*
☐ Sharp, shooting pain · *Dolor agudo y punzante*
☐ Numbness/ Burning · *Entumecimiento/ Ardiente*
☐ Other · *Otra* _____

Rate your level of pain. *Evalúe su nivel de dolor.*
No pain *Sin dolor* ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst pain *Peor dolor*

Patient Information · *Información del paciente* (continued · *continuado*)

When or how often do you experience the pain? Check all that apply.
¿Cuándo o con qué frecuencia experimenta el dolor? Marque todo lo que corresponda.

- ☐ Constant · *Constante*
- ☐ Intermittent · *Intermitente*
- ☐ Daily · *Diariamente*
- ☐ Worse with activity · *Peor con la actividad*
- ☐ At rest · *En reposo*
- ☐ Worse in the morning · *Peor en la mañana*
- ☐ Affecting your job · *Afectando su trabajo*
- ☐ Affecting your sleep · *Afectando su sueño*

Have you seen anyone prior to this appointment? *¿Ha visto a alguien antes de esta cita?* ☐ Yes · *Sí* ☐ No

Have you had any prior foot surgery? *¿Ha tenido alguna cirugía en el pie?* ☐ Yes · *Sí* ☐ No

Do you have any prior x-rays, MRIs, or office notes? *¿Tiene alguna radiografía previa, MRI o notas de la oficina?* ☐ Yes · *Sí* ☐ No

If yes, please list the name of the procedure and date it occured.
En caso afirmativo, por favor indique el nombre del procedimiento y la fecha en que ocurrió.

Medical History · *Historia médica*

Are you pregnant? *¿Estas embarazada?* ☐ Yes · *Sí* ☐ No

Are you nursing? *¿Está usted amamantando?* ☐ Yes · *Sí* ☐ No

Do you smoke? · *¿Fumas?*
- ☐ Everyday · *Cada día*
- ☐ Some days · *Algunos días*
- ☐ Formerly · *Antes*
- ☐ Never · *Nunca*
- ☐ Frequency unknown · *Frecuencia desconocida*

Have you had any of the following? Check only if your answer is yes. · *¿Alugna vez ha tenido alguna de las siguientes afecciones? Marque sólo si su respuesta es sí.*

- ☐ Anemia
- ☐ Angina or chest pain · *Angina o dolor en el pecho*
- ☐ Asthma · *Asma*
- ☐ AIDS/HIV · *SIDA / VIH*
- ☐ Hypertension · *Hipertensión*
- ☐ Cancer · *Cáncer*
- ☐ Congestive heart failure (CHF) · *Insuficiencia cardíaca congestiva*
- ☐ Coronary artery disease · *Enfermedad de la arteria coronaria*
- ☐ Depression · *Depresión*
- ☐ Chronic obstructive pulmonary disease (COPD) · *Enfermedad pulmonar obstructiva crónica*
- ☐ Diabetes
- ☐ Lymphedema · *Linfedema*
- ☐ High cholesterol · *Colesterol alto*
- ☐ Heart attack · *Ataque al corazón*
- ☐ Gout · *Gota*
- ☐ Arthritis · *Artritis*
- ☐ Sleep apnea · *Apnea del sueño*
- ☐ Gastric ulcer · *Úlcera gástrica*
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis · *Artritis reumatoide*
- ☐ Hepatitis or liver disease · *Hepatitis o enfermedad del hígado*
- ☐ Transient ischemic attack (TIA) or stroke · *Ataque isquémico transitorio o accidente cerebrovascular*
- ☐ Kidney disease · *Enfermedad del riñon*
- ☐ Drug abuse disorders · *Trastornos del abuso de drogas*
- ☐ Deep vein thrombosis (DVT) · *La trombosis venosa profunda*
- ☐ Thyroid disease · *Enfermedad de tiroides*
- ☐ Dialysis · *Diálisis*
- ☐ Peripheral arterial disease · *Enfermedad arterial periférica*

Allergies · *Alergias*

Are you allergic to any of the following? Check only if your answer is yes. ·
¿Es usted alérgico a alguno de los siguientes? Marque sólo si su respuesta es sí.

- ☐ Adhesive or tape · *Adhesivo o cinta*
- ☐ Latex · *Látex*
- ☐ Aspirin · *Aspirina*
- ☐ Penicillin · *Penicilina*
- ☐ Local anesthetics · *Anestésicos locales*
- ☐ Iodine dye · *Tinte de yodo*
- ☐ Sulfa drugs, (for example, Bactrim) · *Sulfa drogas (por ejemplo, Bactrim)*
- ☐ Seafood · *Mariscos*
- ☐ Morphine · *Morfina*
- ☐ NSAIDS (Motrin, Alleve, Naprosyn, Ibuprofen)
- ☐ Codeine · *Codeína*
- ☐ Other · *Otra* _____
- ☐ None; I have no known allergies. · *Ninguna; No tengo alergias conocidas.*

Family History · *Historia Familiar*

Do you have a family history of any of the following? Check only if your answer is yes. ·
¿Tiene antecedentes familiares de alguno de los siguientes? Marque sólo si su respuesta es sí.

- ☐ Stroke · *Accidente cerebrovascular*
- ☐ Heart disease or heart attack · *Enfermedad cardíaca o ataque al corazón*
- ☐ Cancer · *Cáncer*
- ☐ Diabetes
- ☐ Other · *Otra* _____

Medication List · *Lista de medicamentos*

Please list all medication you are currently taking.
Por favor liste todos los medicamentos que está tomando actualmente.

☐ Check here if you have attached a list.
Marque aquí si ha adjuntado una lista.

_____

_____

_____

☐ Yes! I would like to receive updates about products and services, special offers, news, and events form Foot and Ankle Clinics of Arizona!
☐ ¡Sí! Me gustaría recibir actualizaciones sobre productos y servicios, ofertas especiales, noticias y eventos de Foot and Ankle Clinics of Arizona.

Doctor's notes · *Notas del doctor*

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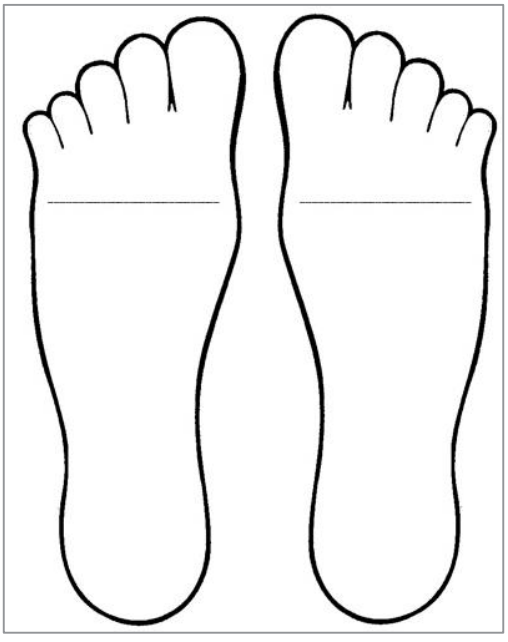

FOOT & ANKLE CLINICS OF ARIZONA

Authorization and Consent

Financial Responsibility

I am aware that benefits are determined by my insurance company and not by the provider. Verification of benefits is not a guarantee of payment, and I will be responsible for any portion of my treatment that is not covered or is denied by the insurance company including my co-payments, deductibles, and co-insurance. I understand that all co-pays and service charges that are not covered by my insurance company will be due at the time of service. I understand the provider is not responsible for the misquotation of benefits from my insurance company. Insurance benefits are determined by my insurance company when the claim is received. I hereby authorize Foot and Ankle Clinics of Arizona to release any information, for insurance purposes, required in the course of my examination or treatment. I hereby authorize payment directly to Foot and Ankle Clinics of Arizona for treatment, if any, otherwise payable to me for services. I understand that I am responsible for all charges if it is determined that the insurance information that I have provided is incorrect. I understand that there will be a $20.00 service charge on all returned checks.

HIPAA / Records Authorization

I, the undersigned understand I have a right to review, if I choose to, Foot and Ankle Clinics of Arizona, Notice of Privacy Practices prior to signing this document, which are available upon request or on our website, yourfeetfixer.com. The privacy of your medical records and personal information is important to us. Documentation of your medical treatment and services rendered are created to provide you with quality care and to comply with certain legal requirements (HIPAA guidelines). Our legal duty is to keep your medical information private and to comply with the terms and conditions of the current notice. We may disclose information for treatment, payment, or to healthcare personnel for the purpose of the quality of your care, and to obtain any authorizations, pre-certifications, etc. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information. Any information you do not wish to disclose must be specified in writing. Any information being requested to be released to anyone besides a referring or treating physician must be submitted to us in writing.

Consent for Treatment

I have read and understand the statements above. I give my permission to the doctor(s) of Foot and Ankle Clinics of Arizona to administer and perform procedures as may be deemed necessary to the diagnosis and/or treatment of me or my dependents' condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment at Foot and Ankle Clinics of Arizona.

Printed patient's name _____

Patient's or parent's signature _____ Date _____