**PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:**

**INSURANCE CARD, PHOTO ID AND MEDICATION LIST**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: \_\_\_\_ MALE \_\_\_\_\_FEMALE Birth Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ PATIENT SSN#: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Guarantors Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_**

**Race: \_\_\_\_Caucasian \_\_\_\_Black/African American \_\_\_\_Native American \_\_\_\_Asian \_\_\_\_\_Hispanic**

**How did you hear about our office? \_\_\_\_\_Physician Referral \_\_\_\_\_Insurance \_\_\_\_\_Friend/Family \_\_\_\_\_\_Internet**

**Why did you choose this office? \_\_\_\_\_ Referral \_\_\_\_\_ Internet Reviews \_\_\_\_\_\_ Location \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Crossroads \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last visit date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEIGHT: \_\_\_\_\_\_ FEET \_\_\_\_\_\_\_\_\_INCHES WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_lbs. MOST RECENT BLOOD PRESSURE \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for today’s visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Have you treated the pain in any way? \_\_\_\_Medication \_\_\_\_Change in Shoe \_\_\_\_\_Stretching \_\_\_\_Other**
* **What is your Pain LEVEL? (NO PAIN) 0----1 ----2----3----4----5----6----7-----8----9----10 WORSE PAIN**
* **How would you describe the pain? \_\_\_\_ Deep Aching \_\_\_\_Sharp Shooting \_\_\_\_Numbness/Burning \_\_\_\_Other**
* **Is the pain? Check all the Apply: \_\_\_\_Constant \_\_\_\_Intermittent \_\_\_\_Daily \_\_\_\_Worse with Activity \_\_\_\_at Rest \_\_\_\_\_Worse in the Morning \_\_\_\_Affecting Your Job \_\_\_\_\_Affecting Your Sleep \_\_\_\_\_**
* **Have you seen other healthcare providers prior to this appointment? \_\_\_\_ YES \_\_\_\_ NO**
* **Do you have any prior X-Rays, MRI’s, or Office Notes today? \_\_\_\_ YES \_\_\_\_ NO**
* **Have you had any prior foot surgery? \_\_\_\_ NO \_\_\_\_ YES Surgery performed and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Are you pregnant? |  | YES |
| Are you nursing? |  | YES |

|  |  |
| --- | --- |
|  | **DO YOU SMOKE? CHECK ONE** |
|  | CURRENT EVERYDAY |
|  | CURRENT SOME DAY |
|  | FORMER |
|  | NEVER |
|  | SMOKER, CURRENT STATUS UNKNOWN |
|  | UNKNOWN |

Please indicate if you have had any of the following: CHECK ONLY IF YES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ANEMIA |  | DIABETES |  | RHEUMATOID ARTHRITIS |
|  | ANGINA/ CHEST PAIN |  | LYMPHEDEMA |  | HEPATITIS/LIVER DISEASE |
|  | ASTHMA |  | HIGH CHOLESTEROL |  | TIA/STROKE |
|  | AIDS/HIV |  | HEART ATTACK |  | KIDNEY DISEASE |
|  | HYPERTENSION |  | GOUT |  | DRUG ABUSE DISORDERS |
|  | CANCER |  | ARTHRITIS |  | DVT/VENOUS THROMBOSIS |
|  | CHF |  | SLEEP APNEA |  | THYROID DISEASE |
|  | CAD/CORONARY ARTERY |  | GASTRIC ULCER |  | DIALYSIS |
|  | DEPRESSION |  | OSTEOPORISIS |  | PERIPHERAL ARTERIAL DIS. |
|  | COPD |  |  |  |  |

Are you ALLERGIC to the following? Check if YES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Adhesive/ Tape |  | Local Anesthetics |  | Morphine |
|  | Latex |  | Iodine Dye |  | NSAIDS- Motrin, Alleve, Naprosyn, Ibuprofen |
|  | Aspirin |  | Sulfa Drugs ex. Bactrim |  | Codeine |
|  | Penicillin |  | Seafood/ Shellfish |  | Other: |
|  | NONE, I HAVE NO KNOWN ALLERGIES | | | | |

Family History: Is there a Family History of the following? Check if YES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | STROKE |  | CANCER |  | OTHER: |
|  | HEART DISEASE/ATTACK |  | DIABETES |  | OTHER: |

Medication List: Check if List Provided: \_\_\_\_\_\_\_

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

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

**LIFETIME INSURANCE ASSIGNMENT AND RELEASE:**

**I, the undersigned certify that I (or my dependent) have insurance coverage as listed, and assign directly to San Tan Foot and Ankle PLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Deductibles/Co-pays/Payments. Our insurance contracts require us to collect deductible amounts and copays at the time of service. These amounts will be collected prior to service being rendered. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept VISA, MasterCard and AMEX, in addition to personnel checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge equal to the bank fee.**

**MEDICARE AUTHORIZATION: IF APPLICABLE, PLEASE COMPLETE:**

**I, the undersigned request that payment of authorized Medicare benefits be made either to me or on my behalf to San Tan Foot and Ankle PLC, for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.**

**HIPAA POLICY:**

**I, the undersigned understand I have a right to review San Tan Foot and Ankle PLC, Notice of Privacy Practices prior to signing this document. San Tan Foot and Ankle PLC, Notice of Privacy Practices may be provided to me upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of San Tan Foot and Ankle PLC. The Notice of Privacy Practices for San Tan Foot and Ankle PLC is also provided in the office waiting room. This Notice of Privacy Practices also describes my rights and San Tan Foot and Ankle PLC’s duties with respect to my protected health information. San Tan Foot and Ankle PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment. The policy is also available on line, at yourfeetfixer.com**

**Consent for Treatment:**

**I certify that the above and attached information is true and correct to the best of my knowledge. I have read and understand the statements above. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child’s 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 San Tan Foot and Ankle PLC.**

**Printed Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Parent Signature Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**