SanTan Foot and Ankle PLC
Medical and Surgical Management of the Foot and Ankle

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 anyone 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, **What and when?**
  _____
  _____
  _____
  _____
  _____

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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: _____

_____
_____
_____
_____
_____
_____

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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.

HIPPA 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 reserve 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: _____