



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

How did you hear about our office?
¿Cómo supo de nuestra oficina?

Physician referral · Referencia del médico
 Friend or family member · Amigo o miembro de la familia
 Insurance · Aseguranza
 Internet

Why did you choose this office?
¿Por qué elegiste esta oficina?

Referral · Remisión
 Internet reviews · Reseñas de Internet
 Location · Ubicación
 Other · Otra _____

Home address · Dirección de la casa _____

City · Ciudad _____ State · Estado _____ Zip code · Código 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 Última fecha de visita

Height _____ Feet · Pies _____ Inches · Pulgadas Weight _____ Lbs. · Libras
Altura 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 _____

Patient Information · Información del paciente (continued · continuado)

Rate your level of pain. <i>Evalúe su nivel de dolor.</i>	No pain <i>Sin dolor</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>	Worst pain <i>Peor dolor</i>
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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.

- | | |
|---|---|
| <input type="checkbox"/> Constant · <i>Constante</i> | <input type="checkbox"/> At rest · <i>En reposo</i> |
| <input type="checkbox"/> Intermittent · <i>Intermitente</i> | <input type="checkbox"/> Worse in the morning · <i>Peor en la mañana</i> |
| <input type="checkbox"/> Daily · <i>Diariamente</i> | <input type="checkbox"/> Affecting your job · <i>Afectando su trabajo</i> |
| <input type="checkbox"/> Worse with activity · <i>Peor con la actividad</i> | <input type="checkbox"/> Affecting your sleep · <i>Afectando su sueño</i> |

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

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

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

If yes, please list the name of the procedure and date it occurred.

En caso afirmativo, por favor indique el nombre del procedimiento y la fecha en que ocurrió.

Medical History · Historia médica

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

Do you smoke? · ¿Fumas?

Everyday · *Cada día* Never · *Nunca*

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

Some days · *Algunos días* Frequency unknown · *Frecuencia desconocida*

Formerly · *Antes*

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

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

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.

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

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

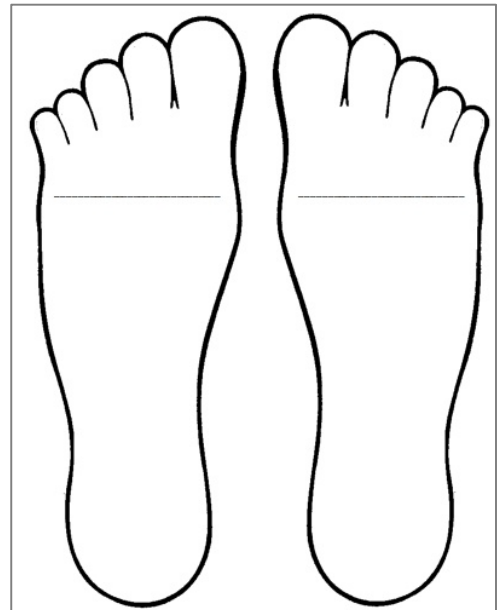
Please list all medication you are currently taking.

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.

Doctor's notes · Notas del doctor



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, precertifications, 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.

I give my consent to Foot and Ankle Clinics of Arizona to discuss my healthcare information with the following person(s)

Name _____ relationship _____ phone _____

this consent shall remain in effect until I give my written permission to terminate it.

- Yes! I would like to receive updates about products and services, special offers, news, and events from 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.

Printed patient's name

Patient's or parent's signature

Date