Patient Information Form

Name:_____Date: _____
Home Phone :(_____)_____ Cell: (_____) _____ Work: (_____)_____
EmailAddress:_____
Permanent Address:_____City:_____Zip:_____
Local Address:_____City:_____Zip:_____
Sex: M____ F_____ Birth Date: _____ Married:____ Divorce: ____ Widowed: ____ Single: ____
In case of Emergency who should be notified? _____ Phone:(_____) _____
Who may we thank for referring you? _____

Additional Information

Primary Care Physician: _____PCP Phone:(_____)_____
Pharmacy Name: _____ Cross Streets: _____ Zip Code: _____
Patient Employer: _____

U.S. Department of Health and Human Services Assessment

The answers to the following questions are optional: Race, Ethnicity, Preferred Language.
Preferred Language:_____ Race:_____Ethnicity:_____

Primary Insurance

I gave a copy of my Primary Insurance Card (Y) / (N)

Policy Holders Name:
Policy Holders DOB:
Policy Holders Soc. Sec.#:
Relationship to Patient:
Address (*if different from patients*)
Insurance Company Name:
Policy or ID #:
Group #:

Secondary Insurance

I gave a copy of my Secondary Insurance Card (Y) / (N)

Policy Holders Name:
Policy Holders DOB:
Policy Holders Soc. Sec.#:
Relationship to Patient:
Address (*if different from patients*)
Insurance Company Name:
Policy or ID #:
Group #:

Who may receive information regarding your Protected Health Information? Check all that apply

Spouse_____Name:_____Date of Birth:_____
Children____Name:_____Date of Birth:_____
Parent/Gaurdian____Name:_____Date of Birth:_____
Significant Other/Friend_____Name:_____Date of Birth:_____
May we leave messages regarding test results and appointments on your answering machine? ____Yes _____No

Assignment and Release

I certify that I, and or my dependent(s) have insurance coverage and assign all benefits directly to the office of *Arcadia Foot and Ankle*. I understand I will be responsible for any portion of the claim, which is denied or not covered by my insurance company. I authorize the release to my insurance carriers any information necessary to process this claim.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider. **Arcadia Foot and Ankle** participates in an organized health care arrangement consisting of the greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of health care to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or health care operations of this organized health care arrangement.

Signed: Date:

ARCADIA
Foot and Ankle
ADVANCED FOOT CARE

NEW PATIENT INFORMATION FORM

Patient Name: _____

Primary Care Doctor: _____ **Referred By:** _____

Please explain why you are here today. (Pain, fracture, injury, etc.)

_____

Have you had recent foot/ankle XRAYS? YES NO When? _____ Where?_____ SMIL SIMON MED

Have you seen any other doctor for this or any other foot/ankle problem? Which Doctor?

_____

Do you grant permission for this office to retrieve records from your previous treating physician? ☐YES ☐NO

Past or Current Medical Conditions

☐Addiction to Alcohol	☐Arthritis (Rheumatoid)	☐Diabetes Type I or II	☐ Cholesterol
☐Addiction to Narcotic	☐Arthritis (Osteo)	☐GI Problems (ulcers, IBS, reflux)	☐Kidney Disorder
☐AIDS/HIV	☐Cancer	☐Heart Disease	☐Liver Disease
☐Anesthesia Problems	☐Chronic Pain	☐High Blood Pressure	☐Vascular Disease
☐Sleep Apnea	☐Asthma / COPD		

Please list any other medial problems: _____

_____

Surgical History

Please list all surgical procedures you have had: _____

_____

Please list all current medications:

(Please include mg and how often)

_____

_____

_____

_____

_____

_____

_____

Family History (please select all that apply)

	Mother	Father	Grandparent
Anesthesia Problems	☐	☐	☐
Arthritis (Rheumatoid)	☐	☐	☐
Arthritis (Osteo)	☐	☐	☐
Cancer	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Vascular Disease	☐	☐	☐

Allergies:

☐None ☐Latex
☐Iodine ☐Metals (rash or blister with jewelry)
☐Codeine ☐Local Anesthetics
☐Sulfa ☐Penicillin

Please list any other allergies:

_____

Social History:

Tobacco Use	☐Yes	☐No	How Much _____
			How Long _____
Alcohol Use	☐Yes	☐No	How Often _____
Rec. Drugs	☐Yes	☐No	Which drugs _____
Currently Pregnant	☐Yes	☐No	Due Date _____

Is there anything else regarding your medical history that is important for your doctor to know?_____

Height:_____ Weight: _____ Shoe size:_____ Occupation:_____

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Patient Financial Responsibility

Patient Name:

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO: **Arcadia Foot and Ankle**

I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and all charges, which are not covered by my insurance. I understand that there will be a **$25.00** service charge on all returned checks. **I understand that verification of benefits is not a guarantee of payment.** (Insurance benefits are determined by your insurance company when the claim is received.) I understand that I will be responsible for any portion of the claim that is allowed by, but not covered by, my insurance company.

Initial: _____ With the exception of Medicare, I understand that if I have secondary insurance, I am responsible for payment of my co-insurance at the time service is rendered. I understand that, upon request, I will be provided with all required documentation to collect reimbursement myself. I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Signature of Responsible Party Printed Name of Responsible Party Date

APPOINTMENT NO SHOW POLICY: I understand that I am responsible for any missed appointments without 24 hour notification and will be responsible for a charge of $75.00.

Signature of Responsible Party Printed Name of Responsible Party Date

RELEASE AND REQUEST OF INFORMATION:

I hereby authorize Arcadia Foot & Ankle to release or request any medical information or incidental information by my referring physician or any other physician who have been or may become involved in my care.

Signature of Responsible Party Printed Name of Responsible Party Date