Sole Foot and Ankle Specialists

5750 W. Thunderbird Rd Ste G 700
Glendale, AZ 85306
Office (602)938-3600 Fax (602)938-0400

Name: _____ **Date of Birth**: _____

Gender: Male/ Female **Preferred Language**: _____

List all and circle preferred **telephone number**:

Home_____ Cell: _____Work: _____

Race (Circle One) White, Black/African-American, Asian, American Indian/Alaskan Native, Pacific Islander/Hawaiian Native; Other

Ethnicity (Circle One) Hispanic/Latin or Non-Hispanic/Latin ; Other

Address:_____
(PO Box or Street) (City) (State) (Zip)

E-Mail Address: _____ Social Security Number: _____

Out of State Address (If Applicable): _____

How Did You Learn About Our Office? (Circle One): Doctor Patient Insurance Internet Other

If Other Please List: _____

Primary Care Physician: _____ Last Visit Date:_____

Emergency Contact

(Who can we notify in case of an emergency?)

Name: _____Relationship: _____

Home Number: _____ Home Address: _____

Responsible Party

(Who is responsible for paying any balance not covered by insurance?)

Name: _____Relationship: _____Date of Birth: _____

Home Phone:_____Address: _____

Work Phone: _____ Social Security Number: _____

Appointment Cancelation Policy: Patients will need to call 24 hours prior to the appointment otherwise there will be a charge of $25.00 to the account.

Patient Signature: _____Date:_____

Signature of guardian if under the age of 18: _____ Date: _____

Patient Name: _____ Date: _____

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Primary Insurance

Name of Insurance Company: _____
Address: _____
(PO Box or Street) (City) (State) (Zip)
Policy Number: _____ Group Number: _____
Insurance Phone Number: _____ Effective Date: _____
Name of Person Insured: _____ Date of Birth: _____
Copay Amount: _____ Annual Deductible: _____

Secondary Insurance

Name of Insurance Company: _____
Address: _____
(PO Box or Street) (City) (State) (Zip)
Policy Number: _____ Group Number: _____
Insurance Phone Number: _____ Effective Date: _____
Name of Person Insured: _____ Date of Birth: _____
Copay Amount: _____ Annual Deductible: _____

Release of Information/ Insurance Assignment **Do We Have Permission To:** Please circle one

Leave a message on your answering machine at home?	Yes	No
Leave a message at your place of employment?	Yes	No
Discuss your medical condition with any member of your household?	Yes	No
If yes, Name: _____ Relationship: _____ Phone Number: _____		

I authorize the release of any medical information necessary to process claims for services I have been provided. I give permission to copy this authorization to be used in place of the original. I authorize Sole Foot and Ankle Specialists to apply for benefits on my behalf for any covered services performed. I request the payment from the insurance company be made directly to Sole Foot and Ankle Specialists. I authorize Sole Foot and Ankle Specialists to contact and forward any pertinent information to my insurance company regardless of whether or not they will provide payment. I certify that the above information is correct.

Patient Signature: _____ Date: _____
Signature of Guardian if under the age of 18: _____

Patient Name: _____ Date: _____

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Patient Medical History

Patient Name: _____ Height: _____ Weight: _____

Pharmacy: _____ Location: _____ Phone Number: _____

Contracted Lab for Services: _____

What types of foot or ankle problems bring you to our office:

_____

_____

_____

Make a check next to any problems you may be currently experiencing or have experienced **in the last year.**

Constitutional (General)
____ NONE
___Fever ____Chills _____Weight Loss _____Weight Gain _____Fatigue _____Difficulty Sleeping
Comments:_____

Eyes
____NONE
___Blurred Vision ___Drainage ____Discharge ___Double Vision ____Decreased Vision ____Dry Eyes
Comments: _____

Ears, Nose, Mouth, Throat
____NONE
____Difficulty Hearing _____Sore Throat ___ Difficulty Chewing _____Difficulty Swallowing
____ Hearing Aids
Comments:_____

Respiratory (Breathing)
____ NONE
____Cough ____Wheezing ____ Shortness of Breath ___Difficulty breathing when lying down flat
____Waking up short of breath
Comments:_____

Cardiovascular (Heart and Circulation)
____NONE
____Chest/ Arm Pressure or Pain ___Cramps in the Legs/ Feet When Sleeping
___Leg cramps/ Calf Pain When Walking _____Sleeps in chair at night _____Swelling in the Legs

Comments: _____

Patient Signature _____

Patient Name: _____ Date: _____

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Gastrointestinal (Stomach and Intestinal System)
____NONE
____Frequent Heartburn ____Abdominal Pains ____Jaundice ____Blood in Stool
____ Black or Tarry Stool ____Nausea ____Constipation ____Diarrhea
Comments: _____

Genitourinary (Genital and Urinary System)
____NONE
____ Inability to Urine Burning/ Pain When Urinating _____ Blood in Urine _____ Incontinence
____ Increased Urination and Decrease Urination
Comments:_____

Musculoskeletal (Muscles and Bones)
____NONE
____Joint Pain ____Joint Stiffness ____Joint Swelling ____Muscle Pain ____Muscle Weakness
____Morning Stiffness ____Neck Pain ____Back Pain ____Hip Pain ____ Knee Pain
Comments: _____

Neurological (Nervous System)
___NONE
____ Tingling ____Pins and Needles ____Numbness ____Headaches ____ Seizures ____Dizziness
____ Shooting Pains ___Increased Sensitivity to Touch/ Pain ___Decreased Sensitivity to Touch/ Pain
____Memory Disturbance
Comments: _____

Skin/Nails
____NONE
____ Allergy to Chemicals ____Thick or Discolored Toenails ____Skin Dryness
____ Thick or Discolored Fingernails ____Scarring after Surgery/ Injury ____Skin Itching
____ Skin Cracking ____Skin Rash ____Skin Cancer
Comments: _____

Psychiatric (Mental and Emotional Challenges)
____NONE
____Bipolar Depression ____Depression ____Anxiety ____Panic Attacks
____Obsessive Compulsive Disorder
Comments:_____

Endocrine (Glands and Hormones)
____NONE
____Increased or Decreased Thirst ____ Cold or Heat Intolerant
____ Difficulty or Delayed Healing _____ Post Menopause

Comments: _____

Patient Signature _____

Patient Name: _____ Date: _____

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Hematological/ Lymphatic (Blood and Lymph System)

___NONE
___Sickle Cell Disease/ Trait _____Anemia _____Easy Burning/ Bleeding and Hemophilia

Comments:_____

Allergic/ Immunologic (Protection Against Disease)

____NONE
____ Night Sweats ____ General Feeling of Being Sick
____ Reaction to Insect Bites/Stings
____ Frequent Infections and/or Difficult or Slow Healing
Comments: _____

Medications

Please list all prescribed medications **and** *non-prescriptions or over-the-counter medicines, vitamins, or supplements* you take on a regular basis and why:

Name	**Milligrams**	**How often**	**Why do you take it?**

Please use the back of the sheet for more medication listing if necessary

Allergies

	Yes	**No**	**Reaction**		**Yes**	**No**	**Reaction**
Penicillin				Novocaine			
Aspirin				Shellfish			
Iodine				Latex			
Sulfa				Codeine			
Adhesive Tape				Other, Please Specify			

Vaccinations

Please List Current Date

Pneumonia	Date:
Flu	Date:

Diabetic Only

Description	**Results**	**Date**	**Doctor Ordered**
A1C			
Fasting Blood Sugar			

Patient Signature _____

Patient Name: _____ Date: _____

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Past Medical History

Do you have or have ever had any of the problems with the following:

Place an X in each box

	Yes	No	Date		Yes	No	Date
Diabetes				Heart Disease			
Alcoholism				Mitral Valve Prolapse			
Chemical Dependence				Heart Attack			
Depression				Hypertension (High Blood Pressure)			
Arthritis				Stroke			
Rheumatoid Arthritis				Thyroid Disease			
Osteoarthritis				Hypothyroid			
Artificial Joints				Hyperthyroid			
Osteoporosis				Kidney Disease			
Asthma				Liver Disease			
COPD/ Emphysema				Lung Disease			
Stomach Ulcer				Thrombosis/ Phlebitis			
Peripheral Neuropathy				Raynaud			
Anemia				Seizure Disorder			
Fibromyalgia				Skin Ulcer			
Coagulation (Disease/ Bleeding)				GERD (Gastroesophageal Reflux Disorder)			
Vascular Disease (Circulation to legs or arms)				Hypercholesterolemia (High Cholesterol)			
Difficulty Hearing				Gout			
Cancer				HIV/ AIDS			

Please describe any other medical problems, including foot problems you have that are not mentioned above: _____

_____

_____

FOR WOMEN ONLY: Are you pregnant?_____ If so, how many months?_____

Last menstrual period: _____

Past Surgical History and Hospitalization

Operation/Serious Injury	Date	Physician	Hospital

Patient Signature _____

Patient Name: _____ Date: _____

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Family History

	Mother	Father	Sibling
Arthritis			
Blood Clots			
Bleeding Problems			
Diabetes			
Gout			
Heart Disease			
Stroke			
Cancer			
Other:			

Marital Status

_____ Married ____Divorced _____ Single _____Widow _____Widowed

_____Children (If yes, how many? _____

Social History

Are you a non-smoker? _____
Are you a current smoker? ____ If yes, how may packs a day? _____ Are you are former smoker? _____ If yes, date you quit? _____ Do you drink alcohol? ____ If yes, number of ounces or drinks per week?
Please circle type(s) Beer, Wine, or Liquor: #ounces/week _____# drinks/week _____
Does your work or lifestyle involve spending large amounts of time on your feet? _____
If yes, Please explain:_____
Occupation: _____
Does your job require you to?:
____Carry ____Run _____Walk ____Climb _____Sit ____Lift _____Stand
Do you exercise? _____If yes, how often and what type(s) of exercise?

_____

Thanks for taking the time to fill out these important forms: We DO CARE about YOU!

Please Print Name: _____Date
DPM reviewed Signature _____Date
Changes Noted and Dated _____

Patient Name: _____ Date: _____

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AUTHORIZATION AND CONSENT TO PHOTOGRAPH, RECORD AND PUBLISH

It is our office policy to take photographs of part or all of the patient's lower extremities (e.g., leg, ankle and/ or foot). I authorize Sole Foot and Ankle Specialists to take and use photograph(s) of my condition for the purposes of, but not limited to, medical documentation, education, research, and scientific or public relations, with the provision that my identity will remain confidential.

In this agreement, the terms "photograph" shall mean still photography or motion picture photography, in any format, as well as videotape, video disc, and any other mechanical or electronic means of recording and reproducing images.

Accept _____ Decline _____ Initials _____

ACKNOWLEDGEMENT FOR LAB SERVICES

I have informed the office the lab company that is contracted with my insurance. If I decide to go to a lab company outside of my network, I will be responsible for any billed charges.

Accept _____ Decline _____ Initials _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Accept _____ Decline _____ Initials _____

ACKNOWLEDGMENT OF RECEIPT FOR OVER THE COUNTER SUPPLIES

We at Sole Foot and Ankle Specialists PC sell over the counter products for your foot care needs. If you decide to purchase our over the counter products, please be advised that these products are non returnable.

Accept _____ Decline _____ Initials _____

Patient Name (please print) _____

Date _____

Parent or Authorized Representative (if applicable) _____

Signature _____

Patient Name: _____ Date: _____

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AUTHORIZATION & ASSIGNMENT OF BENEFITS

****YOUR INSURANCE MAY NOT PAY FOR ROUTINE SCREENING****
****APPROPRIATE SCREENING DIAGNOSES MUST BE PROVIDED WHEN INDICATED****
******PAYMENT DUE THE DAY OF SERVICE******

Services Provided

- I certify the accuracy of the information I have provided to Sole Foot and Ankle Specialists including the information on the applicable insurance benefits page.
- I hereby request that my insurer make payment either to me or, on my behalf, to the company providing services as it pertains to me being treated and receiving medical care by Sole Foot and Ankle Specialists.

Disclosure of financial Interests

- I acknowledge I may receive services for medical care by my practitioner. I understand my doctor may have financial interests for services provided to me by my practitioner. I understand that there are alternative options are available should I decide not to utilize the services provided to me.

- I understand I have the option of using any other facilities of my choice. I understand that I will not be treated any differently if I chose to use another facility.

Payment of Out of-Network Providers

- I understand that some services may not be members of my insurer's network and I am financially responsible for charges, whether or not paid by My Insurer regarding my responsibility of copayments and/or deductibles.

- If My Insurer provides a check to me in payment for the services described above, I shall endorse the check and forward it to company and/or facility that provides me with services within 30 days of receipt. I understand my failure to do so could result in my account being forwarded to collection agency and reported to a credit bureau.

This Authorization and Assignment shall remain effective until revoked by me in writing addressed to
Sole Foot and Ankle Specialists.

A photocopy of this Authorization and Assignment shall be as valid as the original.

Print Name: _____ **Date of Birth**: _____

Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

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Dear Patient: _____

Due to all of the various HMO and PPO insurance plans now available in the marketplace, it has become a very complicated process to become familiar with each plan. All of the various companies and plans have their individual requirements for various procedures.

It has therefore become necessary to request that all patients provide all information needed from their insurance company, and that they assume responsibility for providing this information to our office, and to any other health facility involved in their particular treatment or illness, including hospitals. Patients must also notify their insurance company of any changes in their care or treatment so that proper handling and payment will be made by their insurance company.

You may receive a pre-certification or authorization number from your insurance company. Please remember that this does not guarantee that your insurance company will pay for the procedure. It is your responsibility to call your insurance benefits department to see if you have any pre-existing or routine testing clauses in your contract which would prevent your insurance company from paying the bill.

We have always filed and will continue to file claims for patients, but you must share equal responsibility for obtaining and giving the doctor or insurance company the necessary information needed to get your claim processed and paid within a reasonable time period.

We realize that patients are not always given all the information required by their insurance company or agent, but it is till your responsibility to call and obtain this information before receiving treatment and before filing claims for treatment. We cannot emphasize enough how important this is, in order for you to receive the proper benefit you are entitled to under your insurance plan or contract.

We are requesting your cooperation so that we may better serve you and give you the health care you deserve, without having to spend an exorbitant amount of time dealing with your insurance company. You should leave and know all the information required by your individual plan(s) of insurance to avoid any confusion on your behalf of what services are covered by your insurance policie(s).

Thank you for your cooperation,

_____ _____

Patient Signature or Parent of Minor Date