

Phoenix Foot & Ankle Associates, PC

Date: _____

Name: _____ Date of Birth: _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Email: _____

Address: _____

SS #: _____ Age: _____ Sex: Female Male

Married Single Divorced Widowed Other

Occupation: _____ Employer: _____

Work Address: _____

Primary Insurance: _____

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Secondary Insurance: _____

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Whom may we thank for referring you? _____

In case of an Emergency, contact: _____

Phone: (_____) _____ Relationship: _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Phoenix Foot & Ankle Associates, PC 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 this use of signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

MEDICARE AUTHORIZATION, If Applicable Please Sign

I request that payment of authorize Medicare benefits be made either to me or on my behalf to Phoenix Foot & Ankle Associates, PC, for any services furnished 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 that 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 the 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.

Beneficiary Signature

Date

Phoenix Foot & Ankle Associates, PC

Date: _____ Name: _____

Reason for today's visit: _____

Height: _____ Weight: _____ Shoe Size _____

Please indicate if you have or had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease or Hepatitis |
| <input type="checkbox"/> Allergies to Medicines/Drugs | <input type="checkbox"/> Chest Pain or Angina | <input type="checkbox"/> Diabetic Foot Wound |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma or Respiratory Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke or Heart Attack |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer or Gastritis | <input type="checkbox"/> Anticoagulant Therapy |
| | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Tobacco Use: Yes No Quit Years Smoked: _____

Surgeries: _____

Hospitalizations: _____

Family Physician: _____

Ph.: (_____) _____ Last Visit Date: _____

Are you now, or have you been under any other doctor's care for any reason over the past two years?

Yes No If Yes, please explain: _____

Current Medications: _____

Allergies:

- | | | | |
|--|----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Pain Meds | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Codeine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Seafood | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Steriod |
| <input type="checkbox"/> Other: _____ | | | |

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures such as may be deemed necessary in the diagnosis and treatment of my feet and/or ankle.

Patient Signature

Date