Desert Sports
Foot and Ankle, LLC

PATIENT INFORMATION

PATIENT NAME LAST_____ FIRST _____ MI _____
SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH _____ AGE _____
ADDRESS _____ MALE ____ FEMALE _____
CITY _____ STATE_____ ZIP _____
HOME PHONE _____ WORK/ CELL # _____
MARITAL STATUS SINGLE ____ MARRIED _____ DIVORCED _____ WIDOWED _____
OCCUPATION _____ EMPLOYER _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE _____
EMERGENCY CONTACT _____ PHONE NUMBER _____
PRIMARY CARE DOCTOR _____ PHONE NUMBER _____

REFERRAL INFORMATION

REFERRING PHYSICIAN _____ PHONE # _____
INTERNET ____ INSURANCE ____ YELLOW PAGES _____ OTHER _____
FRIEND OR FAMILY (PLEASE INCLUDE NAME) _____

RESPONSIBLE PARTY INFORMATION

NAME _____ RELATIONSHIP _____
ADDRESS _____ MALE _____ FEMALE _____
CITY _____ STATE _____ ZIP _____
SOCIAL SECURITY # _____ - ____ - _____ DATE OF BIRTH _____
HOME PHONE _____WORK _____ CELL _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____
ADDRESS: _____ CITY _____
STATE _____ ZIP _____ RELATIONSHIP TO PATIENT _____
POLICY # _____ GROUP # _____
PHONE # _____ EFFECTIVE DATE INSURANC_____

SECONDARY INSURANCE COMPANY_____
ADDRESS: _____ CITY _____
STATE _____ ZIP _____ RELATIONSHIP TO PATIENT _____
POLICY # _____ GROUP # _____
PHONE # _____ EFFECTIVE DATE INSURANC_____

Desert Sports
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INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize treatment of the above patient. I hereby authorize Desert Sports Foot and Ankle, LLC to furnish information to insurance carriers regarding my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and dependents. I understand that I am responsible for any CO-PAYMENTS, DEDUCTIBLES OR BALANCES not covered by my insurance.

SIGNATURE _____ DATE_____

NOTICE OF PRIVACY PRACTICES

I Acknowledge that I have received and read Notice of Privacy Practices and understand my rights as a patient in regards to how my medical information is used and the disclosures of my protected health information. I further acknowledge that as of today's date, I have no questions regarding the Notice of Privacy Practices.

PRINTED NAME OF PATIENT_____

SIGNATURE OF PATIENT _____DATE _____

AUTHORIZATION FOR RELEASE OF INFORMATION

At times it may be necessary for us to contact you in regards to your medical care. We will not leave messages on an answering machine, voicemail or with anyone except the patient or legal guardian in attempt to protect your privacy of health information UNLESS you choose to give us permission to do so. If you would like us to leave a message on your answering machine, voice mail or with an individual other than the patient, please give us permission below by checking the appropriate selections and endorsing below.

___ Medical information ___ Financial Information
___ Home phone # _____
___ Cell phone # _____
___ Work phone # _____
___ Other individuals: (name & relationship) _____ _____

SIGNATURE: _____ DATE:_____

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Financial Policy

As our patient, you are responsible for all authorizations/referrals needed to obtain treatment in this office. Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service.

- Payment is expected at time of service. Payment required may be in the form of CO-PAYS, DEDUCTIBLES, CO-INSURANCE or NON-COVERED SERVICES.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. This allows the insurance company to pay the doctor directly.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do *not* have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- For most services provided, we will bill your insurance health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.
- $25.00 fee for any forms which require completion by the doctor such as short term disability (STD), family medical leave (FMLA), etc. Please allow 5-7 business days for completion
- There is a fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- We require a 24 hour notice for cancellation of appointments. A fee of $50 may be charged for each missed appointments not canceled or rescheduled in a reasonable amount of time
- If you have any questions about our financial policy please discuss them with our front office staff or the Office Manager.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party:_____

MEDICAL HISTORY

Height _____ Weight_____ Shoe Size _____

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

___Diabetes
___Heart attack
___Mitral valve prolapse
___Vascular/Circulation disease
___Raynaud's
___High blood pressure
___COPD/Emphysema
___Asthma
___Stroke
___Seizures
___Kidney disease
___Neuropathy/Numbness
___History of blood clots
___Liver disease/ Hepatitis B or C
___Stomach ulcers
___Thyroid disease
___Gout
___Arthritis/Osteoarthritis
___Rheumatoid arthritis
___Artificial joints
___Cancer
___Immune disease (HIV, AIDS)

Other_____

MEDICATIONS (please include dosage of each)

Are you taking any blood thinning medication? (Please circle)
Aspirin / Plavix / Coumadin / Warfarin / Heparin / Lovenox

Do you require antibiotics before any dental work? Yes / No

ALLERGIES (Please Circle)

Penicillin	Sulfa	Codeine	Aspirin	Novocain
Iodine	Shellfish	Adhesive / Tape	Latex	**NONE**

Others: please specify_____

SOCIAL HISTORY

Do you smoke? Yes No Number of pack(s) per day? _____
Do you drink? Yes No How many ounces per week? _____
Illicit Drugs? Yes No _____
Do you exercise? Yes No _____
Occupation_____

FAMILY HISTORY (Please circle)

Do you have a family history of:
Diabetes / Heart disease / Stroke / Cancer / Blood Clots / Bleeding problems / Gout / Rheumatoid Arthritis

SURGERIES & HOSPITALIZATIONS (describe procedure, year, any complications)

_____
_____
_____
_____

REVIEW OF SYSTEMS (please check all that apply)

1) CONSTITUTIONAL
- ▫ None
- ▫ Weight changes
- ▫ Chills
- ▫ Fever
- ▫ Weakness/Fatigue

2) EYES
- ▫ None
- ▫ Vision change
- ▫ Glasses/Contacts
- ▫ Cataracts
- ▫ Glaucoma

3) EARS, NOSE & THROAT
- ▫ None
- ▫ Hearing loss
- ▫ Ear ache or infection
- ▫ Ringing
- ▫ Hoarseness

4) CARDIOVASCULAR
- ▫ None
- ▫ Chest Pain
- ▫ Swelling in legs
- ▫ Shortness of breath
- ▫ Palpitations

5) RESPIRATORY
- ▫ None
- ▫ Shortness of breath
- ▫ Wheezing/Asthma
- ▫ Frequent Cough

6) GASTROINTESTINAL
- ▫ None
- ▫ Heartburn
- ▫ Acid Reflex
- ▫ Nausea or vomiting
- ▫ Abdominal Pain

7) MUSCULOSKELETAL
- ▫ None
- ▫ Arthritis/joint stiffness
- ▫ Muscle aches
- ▫ Swelling of joints

8) SKIN
- ▫ None
- ▫ Rash
- ▫ Ulcers

9) NEUROLOGICAL
- ▫ None
- ▫ Headaches
- ▫ Fainting/blackouts
- ▫ Dizziness
- ▫ Numbness, tingling

10) PSYCHIATRIC
- ▫ None
- ▫ Depression
- ▫ Nervousness
- ▫ Anxiety
- ▫ Mood swing

11) ENDOCRINE
- ▫ None
- ▫ Excessive thirst or hunger
- ▫ Hot/cold intolerance
- ▫ Hot flashes

12) HEMATOLOGICAL
- ▫ None
- ▫ Easy bruising
- ▫ Easy bleeding
- ▫ Anemia

HISTORY OF INJURY

▫ Foot: R L ▫Ankle: R L

Did the problem result from a specific injury? ▫ Yes ▫ No **Injury/Accident Date:**____/____/____

Did your problems begin following: ▫ Work Injury? ▫ Motor Vehicle Accident?
▫ Other: _____

Describe how you got injured?

_____

_____

If neither, how long have you had the condition? _____

Please rate your pain on a scale from 1 to 10 *(10 being the most painful)*:
At Rest: 1 2 3 4 5 6 7 8 9 10 **At its worst:** 1 2 3 4 5 6 7 8 9 10

Is the pain: ▫ **Constant** ▫ **Occasional** ▫ **Sharp** ▫ **Dull** ▫ **Aching** ▫ **Stabbing** ▫ **Throbbing**

What symptoms are you experiencing? ▫ **Locking** ▫ **Catching** ▫ **Giving Way** ▫ **Popping** ▫ **Grinding**

▫ **Other** _____

What, if anything, makes your symptoms **better**? _____

What, if anything, makes your symptoms **worse**? _____

Have you seen another physician for this injury? ▫ **Yes** ▫ **No**

If yes, who? _____ Phone # _____

What treatments have you tried? ▫ **Nothing** ▫ **Physical Therapy** ▫ **Chiropractic** ▫ **Bracing** ▫ **Orthotics**
▫ **Injections** (for example: Cortisone) ▫ **Medications** _____
▫ **Other** _____

Have you had any of the following tests/studies?

Test	*Date (month / year)*	*What facility? (clinic / hospital)*
▫ **X-rays**	_____	_____
▫ **MRI scan**	_____	_____
▫ **CT scan**	_____	_____
▫ **EMG/NCV**	_____	_____

_____Practitioner's Initials / Date