Sonoran Foot and Ankle Institute
New Patient Registration

SONORAN FOOT & ANKLE INSTITUTE

PATIENT INFORMATION (Please Print)

FULL NAME:_____ SOCIAL SECURITY # _____-_____-_____

DATE OF BIRTH:____/____/____ GENDER: ☐ M ☐ F ☐ _____ MARITAL STATUS:_____

ADDRESS:_____ Phone Number (_____) -_____- _____

CITY_____STATE_____ZIP_____ E-MAIL_____

How did you hear about us? ☐ DOCTOR_____MEDIA ☐ _____OTHER_____

PRIMARY CARE PHYSICIAN:_____DATE LAST SEEN_____

PREFERRED PHARMACY:_____

EMERGENCY CONTACT:_____PHONE #_____

Primary Language_____

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native American ☐ Pacific Islander ☐ Indian ☐Northern African

☐ Other_____ ☐ I prefer not to respond

RESPONSIBLE PARTY INFORMATION

(Only fill this in if the patient is a minor or otherwise unable to sign for themselves)

FULL NAME:_____ SOCIAL SECURITY # _____-_____-_____

DATE OF BIRTH:____/____/____ GENDER: ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT :_____

INSURANCE POLICY INFORMATION

PRIMARY INSURANCE POLICY

INS. CARRIER NAME:_____

INS. ID #_____ POLICY/GROUP #_____

PRIMARY INSURED NAME:_____PRIMARY'S DOB:_____/_____/_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER_____

SECONDARY INSURANCE POLICY (IF APPLICABLE)

INS. CARRIER NAME:_____

INS. ID #_____ POLICY/GROUP #_____

PRIMARY INSURED NAME:_____PRIMARY'S DOB:____/____/_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER_____

The above information is true to the best of my knowledge. I consent to be contacted by this office or any of its affiliates via any contact means I have provided, or that have been provided by someone acting on my behalf. Some contact means may result in data charges. I understand that I am financially responsible for any balances incurred by me or any individual I have legal responsibility for. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremities with my consent.

Patient or Responsible Party Signature: _____ Date _____

Sonoran Foot and Ankle Institute
New Patient Medical History Form

SONORAN FOOT & ANKLE INSTITUTE

ALLERGIES

Please list any allergies that you have here, including the reaction (for example, Penicillin – Rash): _____

_____

Do you have an allergy to: ☐ iodine ☐ tapes/adhesives ☐ metal/nickel ☐ local anesthetic (e.g., lidocaine) ☐ latex

MEDICATIONS (Please list all medications and dosages)

_____

_____

_____

MEDICAL DIANGOSIS AND HEALTH HISTORY

Do you have a history of any of the following conditions? Please circle **all** items that apply to you.

Anemia	**Anxiety**	**Arthritis**	**Asthma**
Atrial Fibrillation	**Back Pain**	**Bipolar Disorder**	**Bleeding Disorder**
Blood Clot or DVT	**COPD**	**Cancer, Type _____**	**Cholesterol High**
C. Regional Pain Syndrome	**Congestive Heart Failure**	**Coronary Artery Disease**	**Dementia**
Depression	**Dermatitis**	**Diabetes**	**Dialysis**
Edema/Leg Swelling	**Epilepsy**	**Fibromyalgia**	**GERD**
Glaucoma	**Gout**	**HIV/AIDS**	**Headache**
Heart Attack/M.I.	**Heart Disease**	**Hepatitis**	**Hypertension**
Kidney Disease	**Liver Disease**	**Lung Disease**	**Osteoporosis**
Peripheral Vascular Disease	**Pulmonary Embolism**	**Raynaud's Disease**	**Rheumatoid Arthritis**
Stents in Heart	**Stroke**	**Substance Dependency**	**Thyroid Disease**
Tuberculosis	**Ulcer (GI/Stomach)**	**Varicose Veins**	

Other_____

If female: Are you currently pregnant or nursing? YES NO N/A

PRIOR SURGERIES

Have you ever been exposed to general anesthesia? YES NO

Have you ever had a problem with anesthesia? YES NO If YES, explain: _____

Please list any surgeries that you have had in the past, including dates: _____

_____

_____

Have you ever had any testing or procedures done on the arteries or veins in your legs? YES NO

Have you ever had any surgery or stents placed in your heart or elsewhere in your body? YES NO

If YES to either above, please explain: _____

SOCIAL HISTORY

Tobacco Use: ☐ Never ☐ Former ☐ Current Frequency_____ Years of use _____

Alcohol Use: ☐ None ☐ Rare ☐ Occasional ☐ Moderate ☐ Heavy

Recreational Drugs ☐ Never ☐ Previously ☐ Socially ☐ Daily Type _____

Exercise: ☐ Inactive ☐ Light ☐ Moderate ☐ Heavy ☐ Inactive due to current symptoms

Occupation: _____

FAMILY HISTORY

Mother Alive Deceased Medical History/Cause of Death:_____

Father Alive Deceased Medical History/Cause of Death:_____

Sibling(s) Medical Conditions/Cause of Death_____

Sonoran Foot and Ankle Institute
New Patient Review of Systems Form

SONORAN FOOT & ANKLE INSTITUTE

PRESENT HEALTH – REVIEW OF SYSTEMS

What is your current/most recent **Height**_____ **Weight**_____

*Please review and mark **ALL** items that have applied to you **within the last month** (including today)*

Constitutional: ☐ weight loss ☐ weight gain ☐ fevers ☐ fatigue

Head: ☐ congestion ☐ hearing loss ☐ sore throat ☐ difficulty swallowing ☐ nose bleeds

Eyes: ☐ blurred vision ☐ cataracts ☐ glasses ☐ glaucoma

Chest/Heart: ☐ chest pain ☐ palpitations ☐ shortness of breath ☐ cough ☐ difficulty breathing

Gastrointestinal: ☐ nausea ☐ vomiting ☐ constipation ☐ diarrhea ☐ liver problems

Musculoskeletal: ☐ joint pain ☐ back pain ☐ muscle aches ☐ history of fractures ☐ decrease in strength

Psychiatric: ☐ changes in mood or behavior ☐ depression

Skin: ☐ rash ☐ unusual skin changes ☐ sores/lesions ☐ warts ☐ skin disorders

Neurological: ☐ numbness ☐ tingling in extremities ☐ weakness ☐ dizziness ☐ problems with coordination

Endocrine: ☐ diabetes ☐ increased sensitivity to temperature ☐ thyroid problems

Hematologic: ☐ easy bruising/bleeding ☐ anemia ☐ blood thinners ☐ enlarged lymph nodes

Immunologic/Allergic: ☐ autoimmune disease ☐ chronic rash ☐ asthma

OTHER: _____

TODAY'S VISIT

What is the main reason for your visit today? _____

When did you notice the problem? _____

How would you describe your pain? ☐ Aching ☐ Burning ☐ Stabbing ☐ Throbbing ☐ Sharp ☐ Sore ☐ Dull ☐ Occasional ☐ Frequent ☐ Constant ☐ Worsening ☐ Improving ☐ Unchanged ☐ Not Applicable

What is the severity of your pain? (very mild) 1 2 3 4 5 6 7 8 9 10 (severe, excruciating, intolerable) ☐ N/A

What is the timing of your pain? ☐ unsure ☐ chronic ☐ abrupt ☐ gradual ☐ recurrent ☐ intermittent/episodic ☐ n/a

When do you have pain? ☐ All the Time ☐ in the morning ☐ at night ☐ after activities ☐ during activities ☐ at rest

☐ other: _____Have you had this pain before? ☐ NO ☐ YES

Was this an Injury? NO YES If YES, please explain: _____

What makes the pain better? ☐ nothing helps ☐ position change ☐ limited weight bearing ☐ medication ☐ ice ☐ removal of shoes ☐ removal of pressure ☐ inactivity ☐ not applicable

What makes it worse? ☐ cannot identify ☐ walking ☐ shoes ☐ pressure ☐ weight bearing ☐ not applicable

Have you had any of the following? ☐ swelling ☐ redness ☐ warmth ☐ instability ☐ drainage ☐ fevers ☐ chills

Have you had any of the following treatments for this problem in the past? ☐ surgery ☐ orthotics ☐ injections ☐ prior imaging (X-rays, MRI, CT, etc.) ☐ antibiotics ☐ Other: _____

Sonoran Foot and Ankle Institute
Financial and Patient Responsibilities Policies

Thank you for choosing Sonoran Foot and Ankle Institute (SFAI). for your foot and ankle care needs. The following financial policy is in place to assist you with questions regarding your financial obligation in seeking care at SFAI Locations. We ask that you please review and confirm with your signature below.

PAYMENT METHODS

For your convenience, acceptable forms of payments are cash, check, money order, VISA, MasterCard, American Express, or Debit cards. Please note: if a personal check is returned for insufficient funds, there will be a $25.00 fee added to your account.

INSURANCE BILLING

It is your responsibility to be aware of your benefits with your insurance. It is your responsibility to confirm that your individual doctor is in fact a provider under your insurance. We will submit a claim for payment of medical services provided during your visit to your insurance as a courtesy to you. You are responsible for any copays or deductibles not covered by your insurance. **Patients are ultimately financially responsible for all medical services provided**. Secondary insurance claims are filed as a courtesy, and unpaid reimbursement from these plans become the responsibility of the patient after 60 days of non-payment.

If your insurance information, copay, or coverage has changed at any time during your treatment, it is your responsibility to notify the office with the most current and up-to-date information.

PATIENT RESPONSIBILITIES

Referrals: It is your responsibility to provide us with any referral required by your insurance.

Copay: Your insurance may require we collect your assigned copay at the time of your appointment. If you do not have or are unable to pay your copay at the time of your appointment, please work with our staff in rescheduling your appointment at a time that is convenient for you. For patients with a high deductible health insurance policy who require surgery, the surgery copay will be collected at the time your surgery is scheduled, PRIOR to performing surgery. If your condition requires continued medical attention and are unable to pay your copay our office will assist the best we can to accommodate your needs and ensure your health care requirements are met.

Payment arrangements: If a circumstance arises where payment arrangements are approved, the discount will be taken after all payments are received. If you fail to adhere to your payment agreement, your full balance will be due immediately.

Cancellations and missed appointments: In consideration of both your and your physician's time, our office requests **24-HOUR NOTICE** to cancel or reschedule your scheduled appointment. Any cancellations or rescheduled appointments that do not provide 24-hour notice will be assessed a $25.00 fee AND will be reported to your insurance. Patients who fail to call in advance, or no-call no-show their appointments three times will promptly be dismissed from SFAI, all prior commitments of continued care by SFAI will be forfeit by the patient at that point.

Self-Pay or Cash Pay: Self-pay and cash accounts are eligible for a discount, which is due prior to any services; NO payment arrangements are made when any discounts have been applied.

Collections: After a balance is past-due for 90 days, your information will be sent to a collection agency. If your account is referred to a collection agency, you will be responsible for all associated additional billing and collection costs.

BILLING INQUIRIES

If you have any questions regarding a bill from our office, please feel free to contact our office during regular business hours.

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, and understand, and agree to the above financial policy. Regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I authorize the release of any medical information necessary to process a claim for benefits under my policy and assign payment to this office.

Patient or Responsible Party Signature: _____ **Date**: _____

Sonoran Foot and Ankle Institute
Prescription Pain Management Policy

Foot and ankle pain can be difficult to manage. Most painful foot and ankle conditions are short-term, and your physician will attempt all reasonable non-surgical, and non-prescription methods of alleviating your pain, though occasionally prescription medication is required. The Sonoran Foot and Ankle Institute has established the following guidelines to aid in decision making and protect patient's health during the use of prescription pain medication.

1. Pain medications except for anti-inflammatories, will not be prescribed prior to attempting alternative methods of pain relief for your condition, with the following exceptions: Severe Trauma (Broken bones, crush injuries)
2. After outpatient surgery, patients will receive pain medications pre-determined during the preoperative visit with their surgeon.
3. After inpatient surgery, patients will receive pain medications on discharge as necessary determined by their inpatient assessments.
4. Medication refills for **OPIATE** prescriptions will be limited to **TWO WEEKS** after surgery. In consideration of continued follow-up care, unless a surgical complication exists, there will be no further controlled pain medications prescribed.
5. At their discretion, physicians may refer patients to a pain management company for prolonged pain management.
6. A covering physician may prescribe pain medication determined adequate until your surgeon returns.
7. **There will be no pain medications prescribed over the weekend.** It is your responsibility to verify your medical and prescription needs in advance, as appropriate. There will be no pain medications prescribed after 3pm Fridays.

I understand and agree to the following:

- I will candidly provide my physician with a complete and accurate treatment and medication history, including past medical records, past pain treatment, psychiatric history, and alcohol and other drug addiction history.
- I will take my medication as directed by my physician and will not horde, sell or share my medication.
- Because alcohol and recreational drugs should not be mixed with narcotics, I will not take them together
- I will inform my physician before taking naturopathic products or over-the-counter medications.
- I will **not** obtain narcotics from any other physician, including associates of my physician who may be taking his/her calls.
- I will obtain narcotics from one pharmacy and notify my physician of any changes in the pharmacy.
- I understand that if my narcotic medication should be lost, destroyed, stolen, etc., my physician will **NOT refill** it early.
- I understand that my physician may share prescription information with other providers as necessary for my continued care.
- I understand that no guarantee or assurance has been made as to the results of any prescription therapy.
- **Female Patients:** I affirm that I am not pregnant and that I will immediately notify my physician if I plan to or do become pregnant.

I have read and fully understand this form. I understand that ANY breaches in this mutual agreement regarding prescription pain medication will be cause for cancellation and refusal of prior and future prescriptions. By refusing to sign this consent, I understand that no pain-controlling prescriptions will be issued to me by my physician at ANY point during my cae.

Patient or Responsible Party Signature: _____ **Date**: _____