Sonoran Foot & Ankle Institute
New Patient Registration

SONORAN FOOT & ANKLE INSTITUTE

PATIENT INFORMATION (Please Print)

FULL NAME:_____ DATE OF BIRTH:_____/_____/_____

PRIMARY CARE PHYSICIAN:_____PREFERRED PHARMACY:_____

EMERGENCY CONTACT:_____PHONE #_____

☐ **My scanned identification card and contact information is up-to date (*Do not complete below*)**

GENDER: ☐ M ☐ F ☐ _____ MARITAL STATUS:_____ PHONE NUMBER (_____) -_____- _____

ADDRESS:_____

CITY_____STATE_____ZIP_____ E-MAIL_____

INSURANCE POLICY INFORMATION

☐ **My scanned insurance card is up-to date (*Do not complete below*)**

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_____

I confirm that the information provided is true and accurate to the best of my knowledge. I consent to be contacted by this office or its affiliates using the contact details I or my representative have provided, understanding that standard data or message charges may apply. I accept financial responsibility for any balances owed by myself or by any individual for whom I am legally responsible. I authorize the doctor to perform examinations, procedures, and treatments as deemed necessary for the diagnosis and care of my lower extremities, with my consent.

FINANCIAL OBLIGATION(S) POLICY

Thank you for choosing Sonoran Foot and Ankle Institute (SFAI). Patients are responsible for all charges not covered by insurance, including copays, deductibles, and balances. Payment is due at the time of service, and we accept cash, check, money order, or major credit/debit cards (returned checks incur a $25 fee). We bill insurance as a courtesy, but it is your responsibility to confirm benefits, provider status, and notify us of changes in coverage. Referrals, if required, must be provided by you prior to your initial evaluation. Missed appointments or cancellations without 24-hour notice may result in a $25 fee, and repeated no-shows may lead to dismissal from the practice. Balances older than 90 days may be sent to collections, with additional costs becoming your responsibility. Self-pay and cash patients are eligible for a discount when payment is made in full at the time of service. By signing below, you acknowledge and agree to this policy and authorize release of medical information needed to process claims and assign payment to SFAI.

Patient or Responsible Party Signature: _____ Date _____

Sonoran Foot & Ankle Institute
New Patient Medical Intake 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 or attach a list with 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.

Asthma/COPD	**Arthritis**	**Back Pain**	**Blood Clot or DVT**
Cholesterol High	**Coronary Artery Disease**	**Diabetes**	**Edema/Leg Swelling**
Fibromyalgia	**Gout**	**Heart Attack/M.I.**	**Hypertension**
Kidney Disease/ Dialysis	**Osteopenia/ Osteoporosis**	**Peripheral Vascular Disease/PAD**	**Rheumatoid Arthritis**

Other_____

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

PRIOR SURGERIES

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

_____

_____

SOCIAL HISTORY

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

Alcohol Use: ☐ None ☐ Rare ☐ Socially ☐ Daily

Substance Use: ☐ Never ☐ Rare ☐ Socially ☐ Daily Type _____

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

Occupation: _____

FAMILY HISTORY

Notable medical conditions in your parents/siblings: _____

TODAY'S VISIT

What is the main reason for your visit today? _____

Onset: ☐ Acute ☐ Chronic Timing: ☐ Intermittent ☐ Constant ☐ Recurrent

Pain Type? ☐ Aching ☐ Burning ☐ Sharp ☐ Throbbing Pain Rating (0-10): _____

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

What makes the pain better? ☐ Rest ☐ Ice ☐ Bracing ☐ Medication ☐ Other_____

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

Previous Treatments: ☐ surgery ☐ orthotics ☐ injections ☐ prior imaging ☐ Other: _____

Sonoran Foot & 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 (other than refills) 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 care.

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