AZ RED MOUNTAIN FOOTCARE PATIENT REGISTRATION

Patient Information:

Last Name:_____ First: _____ Middle Init: _____

SS#: _____ Date of Birth: _____ Male ○ Female ○

Full Time AZ Resident?: Yes ○ No ○

AZ Address: _____ City _____ ZIP Code: _____

Home Phone #: _____ Cell Phone #: _____

E-mail: _____

Out of State
Address: _____ City _____ State: _____ ZIP Code: _____

Employer: _____ Work Phone #: _____

Spouse / Significant Other / Guardian Name: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____ City: _____

Major Crossroads: _____

Family Doctor: _____ Phone #: _____

City: _____ State: _____ ZIP Code: _____

Insurance Name: _____

Policy Holder's Name: _____

SS#: _____ Date of Birth: _____

How did you find our office? Please select one and describe:

○ Referred by Friend – Name: _____

○ Doctor Referral ○ Drove By and Saw Sign ○ Phone Book ○ Insurance List

○ Internet Search for: _____

Authorization to Release Information and Assignment of Benefits:

I authorize payments of medical benefits to AZ Red Mountain Footcare or its providers for services rendered or to be rendered in the future without obtaining my signature on each claim submitted and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary for treatment. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL CHARGES RELATING TO MY CARE. If this should need to be referred to a collection agency, I will be responsible for any collection and / or legal fees incurred. My signature below indicates that I have read and also understand the office policy and procedures.

Responsible Party: _____ Date: _____

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New Patient History

Last Name: _____ First: _____

DOB: / / _____ Age: _____ Height: _____ Weight: _____

MARK CONDITIONS FOR WHICH YOU HAVE BEEN TREATED:

☐ Anemia	☐ Arthritis	☐ Gout	☐ Asthma
☐ Bleeding Problems	☐ Cancer	☐ Epilepsy	☐ Diabetes - Type ◯ I ◯ II
☐ Fibromyalgia	☐ Heart Disease	☐ Peripheral Vascular Disease	
☐ Hepatitis	☐ MRSA	☐ High Blood Pressure	☐ Infectious Disease
☐ Kidney Disease	☐ Liver Disease	☐ Stomach ulcer	☐ Raynauds
☐ DVT	☐ RSD	☐ Legally Blind	☐ Hearing Impaired
☐ COPD	☐ Substance Abuse		

☐ Other Conditions Not Listed: _____ _____ _____

☐ None of the Above

Please list your medication by name. No dosage required:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Mark any of the following to which you are allergic:

☐ Penicillin	☐ Keflex	☐ Augmentin	☐ Aspirin	☐ Codeine
☐ Vicodin	☐ Percocet	☐ Sulfa	☐ Neosporin	☐ Topical Iodine
☐ Epinephrine	☐ Latex	☐ Other _____	_____	

Mark any of the following major surgeries you have had:

☐ Brain	☐ Neck	☐ Back	☐ Shoulder	☐ Elbow	☐ Hand
☐ Liver	☐ Kidney	☐ Lung	☐ Stomach	☐ Gall bladder	☐ Eye
☐ Skin	☐ Cosmetic	☐ Hip	☐ Knee	☐ Ankle	☐ Foot
☐ Heel	☐ Toe	☐ Other _____	_____		

Family History: Check M (Mother) and/or F (Father)

Diabetes ☐M ☐F Heart Disease ☐M ☐F Arthritis ☐M ☐F Cancer ☐M ☐F

Hypertension ☐M ☐F Bunions ☐M ☐F Other conditions _____

Father living? ◯Yes ◯No Mother living? ◯Yes ◯No

Social History:

◯Married / ◯Single

Living arrangements: ◯With spouse ◯Significant other ◯Alone ◯Assisted living ◯With children

Tobacco use: ◯Never ◯Quit – Year _____ ◯Yes I do and have no plan to quit

Retired: ◯Yes ◯No Employed outside the home: ◯Yes ◯No

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Podiatric history and HIPPA

Last Name: _____ First: _____

What conditions are you being seen for today?

☐ Heel pain	☐ Ingrown nail	☐ Bunion	☐ Nail fungus	☐ Skin and nail care
☐ Hammertoe	☐ Infection	☐ Nerve pain	☐ Ulcer / wound	☐ Diabetic foot check
☐ Injury	☐ 2nd Opinion	☐ Other _____		

Which foot is affected? ○ Right ○ Left ○ Both

How long has it been a problem? _____ Days _____ Weeks _____ Months _____ Years

Has this problem been treated before? ○ Yes ○ No

Have you ever had foot surgery? ○ Yes ○ No

Do you wear orthotics? ○ Yes ○ No

Do you do any of the following on a regular basis?

☒ Run	☐ Walk for exercise	☐ Hike	☐ Basketball / Baseball / Football
☐ Racket sports	☐ Bowling	☐ Golf	☐ Dancing
☐ Ballet	☐ Motocross	☐ Cross-fit	☐ Martial arts

Does your job involve prolonged standing or walking? ○ Yes ○ No

Do you have any other health concerns we need to know about? ○ Yes ○ No (if Yes, please explain)

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review or provided with a copy of the Notice of Privacy Practices and that I have read or have had the opportunity to read if I so chose to do so. In signing below, I admit an understanding of the Privacy Practice as it applies to my health records and information.

Patient Name: **(PRINT)** _____

Today's Date: _____ / _____ / _____

Parent or Authorized Representative: (if applicable) _____

Patient or Guardian SIGNATURE: _____

I authorize Medical Information to be disclosed to the following people / persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____