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: ___________________________

AZ RED MOUNTAIN FOOTCARE (page 2 of 3)

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

AZ RED MOUNTAIN FOOTCARE (page 3 of 3)

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: ____________________