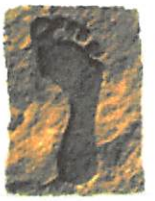

CORAL DESERT
FOOT & ANKLE

PATIENT INFORMATION:

Name: First: _____ Last: _____ MI: _____

Social Security #:_____-_____-_____ DOB:_____/_____/_____

Phone Number: _____ Cell:_____

Physical Address:_____

City:_____ State:_____ Zip:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Marital Status: Single Married Divorced Widow

Additional Contact Information:

Spouse/Guardian/Parent:_____

Phone Number:_____ Cell:_____

Emergency Contact:_____

Phone Number:_____ Relationship:_____

Employment Information:

Employer:_____ Phone:_____

Address:_____City:_____State:_____Zip:_____

Occupation:_____ Supervisor:_____

Employment Status: Full Time Part Time Unemployed Retired

How did you hear about our office: _____

Referral Name:_____

Medical History:

Patient Name First:_____ Last:_____ MI:____

Height:_____ Weight:_____ Shoe Size:_____

Primary Physician:_____ Office Phone:_____

Date last Seen:_____

Preferred Pharmacy:_____

What currently bothers you about your Feet and Ankles? How long has it bothered you?

_____

How is you general health: Good Fair Poor

Please list any other health conditions not listed below:

_____

Have you ever been treated for the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ BPH
- ☐ Coronary Artery Disease
- ☐ CHF
- ☐ Dementia
- ☐ Epilepsy
- ☐ HIV
- ☐ Heart Attack
- ☐ Stroke
- ☐ Anxiety
- ☐ Asthma
- ☐ Back Problems
- ☐ COPD
- ☐ Depression
- ☐ GERD
- ☐ Headache
- ☐ Migraine.
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Dermatitis
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Renal Stone
- ☐ Ulcer

Medications:
Please list medications, including drug name and dosage:

Allergies:
Please list allergies to medications:

Surgical History:

Please list all previous foot surgeries:

_____

Social History:

Are you a current or former smoker: Current Former Never

Do you drink alcohol: Yes No

Do you use recreational drugs: Yes No

Family Medical History:

Have your parents, siblings or children had any of the following:

Heart Problems Diabetes High Blood Pressure Kidney Disease Arthritis

Insurance Information:

Primary Insurance Name:_____

Policy Holder Name:_____

DOB_____/_____/_____

CoPay: _____

Policy Holder: Self Spouse Child Other

Secondary Insurance Name:_____

Policy Holder Name:_____

DOB: _____/_____/_____

CoPay:_____

Policy Holder: Self Spouse Child Other

Responsible Party:

- ☐ Patient
- ☐ Policy Holder
- ☐ Other

Patient and undersigned, if other than patient, each jointly and severally agree to pay for all of the health care services rendered to the patient in this facility including but not limited to, any amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the patient, remains responsible for all co-payments, deductibles, co-insurance and/or non-covered services regardless of amount paid by insurance or third party payer. It is understood and agreed that charges not paid in a timely fashion may be placed for collection of an attorney for purposes of collection. It is further understood and agreed by the patient and the undersigned, that any amounts not paid within 30 days from the date of the facilities bill or statement shall accrue interest at the rate of 1.5% per month on the unpaid balance. In the event that any unpaid balance is placed for collection or with an attorney, patient and the undersigned, if other then the patient, each jointly and severally agree to pay the cost of collection (up to 50% of the unpaid balance) reasonable attorney's fee in connection with the collection process, and all the cost of litigation. A service charge of $25 may be collected in connection with any check or other instrument tendered by me but returned unpaid to the facility.

Signature of Responsible Party:_____Date:_____

Relationship to Patient:_____

Dr. Jeffrey L. Stewart
Dr. Brent A. Clark
Foot and Ankle Specialist

I authorize any holder of medical or other information about me to release to the social security administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim, I permit a copy of this authorization to be used in place of the original, and request of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

(Section 1128 of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding the information) Regulations pertaining to Medicare of benefits also apply.

Signature: _____ **Date:** _____

Patient Payment and Information Authorization:

I authorize release of information to my insurance company
I understand that I am responsible for my bill
I authorize payment directly to my physician
I authorize use of this form on all insurance submissions.

Please list all insurance companies you wished to be billed:

_____

_____

I hereby give my permission to the doctor to examine and treat my feet and ankles.

Signature of Responsible Party: _____ **Date:**_____
Relationship to Patient: _____
Witness: _____

Privacy Practice Acknowledgment:

I have been given the opportunity to review the Notice of Privacy Practices. And obtain a copy at my discretion. (Located at the front desk)

Patient Signature:_____ **Date:**_____
Relationship to Patient: _____

CORAL DESERT
FOOT & ANKLE

Patient Communication Form

Family and Friends: It is the office policy of Coral Desert Foot and Ankle not to release confidential medical information regarding your treatment to your family members or friends, except for (i) Parent/Legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, If you bring a family member or friend into the exam room, we will assume, emergent situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate below, so that we may best serve you. If you do not want any of your medical information provided to a family member please check the line next to the "no" response. By signing below you authorize the following people to receive the information regarding your treatment of care. (If you wish to add names later on, please confirm in writing or calling the staff.)

Spouse: _____ Yes: _____ No:_____

Parent: _____ Yes: _____ No: _____

Other: _____ Yes: _____ No: _____

_____ Yes: _____ No: _____

Alternative Communication: You are also entitled to specify alternative means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:

_____

_____.

Printed Name: _____

Signature: _____ Date: _____

Changes were authorized by the patient over the phone:

Change: _____

Date: _____ Staff initials:_____