CORAL DESERT
FOOT & ANKLE

Patient Information

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender Sex: ☐ Male ☐ Female

Home Ph#( )_____ Cell Ph#:( )_____ Work Ph#:( )_____

Mailing Address_____ Apt #:_____

City_____ State_____ Zip_____

Would you like to receive e-mail reminders for appointments? ☐ YES ☐ NO

E:mail:_____

Additional Contact Information

Spouse/Guardian/Parent: _____

Home Ph#:( )_____ Cell Ph#:( )_____

Emergency contact outside the residence: Name: _____

Home Ph#:( )_____ Cell Ph#:( )_____ Relation: _____

Who referred you to our office? Name:_____

☐ Patient ☐ Friend ☐ Family ☐ Doctor ☐ Phone book ☐ Internet ☐ Other_____

Employment Information

Employment Status: ☐ Part-time ☐ Full-time ☐ Unemployed ☐ Retired

Employer_____

Address_____City_____State_____Zip_____

Occupation:_____ Supervisor:_____

Insurance Information

Primary Insurance Company Information

Insurance Name:_____

Policy Holder Information:

Relationship to patient (check):

☐ Self ☐ Spouse ☐ Child ☐ Other

Please fill out if DIFFERENT from patient*

Full Name: _____

Date of Birth:____/____/_____(MM/DD/YYYY)

Social Security Number :_____-_____-_____

Copay $_____ Verified _____

Secondary Insurance Company Information

Insurance Name: _____

Policy Holder Information:

Relationship to patient (check):

☐ Self ☐ Spouse ☐ Child ☐ Other

Please fill out if DIFFERENT from patient*

Full Name: _____

Date of Birth:____/____/_____(MM/DD/YYYY)

Social Security Number :_____-_____-_____

Copay $_____ Verified _____

Responsible Party

Who is responsible for the bill? ☐ Patient ☐ Policy Holder Other_____

Address_____City_____State_____Zip_____

Home Ph#( )_____ Cell Ph#:( )_____ Work Ph#:( )_____

Patient and undersigned, if other than patient, each jointly and severally agree to pay for all 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 or an attorney for purposes of collection. It is further understood and agreed by the patient and the undersigned, if other than patient, that any amounts not paid within thirty (30) days from the date of the facility's bill or statement for payment shall accrue interest at the rate of 1 1/2 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed for collection or with an attorney for collection, patient and the undersigned, if other than the patient, each jointly and severally agree to pay costs of collection (up to 50% of the unpaid balance), reasonable attorney's fee in connection with the collection process, and all costs of litigation. A service charge of $15.00 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:_____

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Medical History Information

Name Last:_____ First:_____ MI:_____

Social Security #:_____--_____--_____ Date of Birth:____/____/_____(MM/DD/YYYY)

Height: _____ Weight: _____ Shoe Size: _____

Primary Physician: _____ Office Ph#: ( )_____

Last Seen: _____ (MM/YYYY)

How is your general health? (circle) Poor Fair Good

Have you ever been treated for the following conditions?

Arthritis	☐ Yes ☐ No	Eye Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Respiratory Problem	☐ Yes ☐ No
Insulin Dependent	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Skin Problems	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Numbness/Dizziness	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No	Liver Problems	☐ Yes ☐ No

Are you now or have you been under the care of a doctor during the past two years? ☐ Yes ☐ No

If yes, what condition(s)? _____

What surgeries have you had? _____

Do you smoke? ☐ Yes ☐ No ☐ On Occasion How Much? _____

Do you drink? ☐ Yes ☐ No ☐ On Occasion How Much? _____

Medications:

☐ See Attached List

☐ No Current Medications

Drug Allergies: ☐ None

☐ Adhesive/Tape ☐ Novocaine

☐ Aspirin ☐ Latex

☐ Codeine ☐ Penicillin

☐ Cortisone ☐ Sulfa

☐ Other _____

Have your parents or any blood relatives had any of the following conditions?

☐ High Blood Pressure ☐ Heart Problems ☐ Diabetes

☐ Arthritis ☐ Kidney Disease ☐ Cancer

What currently bothers you about your feet and ankles?

Does it bother your: Right Left Both

How Long has it bothered you? _____

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FOOT & ANKLE

Dr. Jeffrey L. Stewart
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 payment 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 my insurance submissions.

(Please name all insurance companies you wished billed)

_____

_____

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

Date: _____

Signature of Responsible Party: _____

Signature of Witness: _____

Privacy Practices Acknowledgment:

I have received the *Notice of Privacy Practices* I have been provided an opportunity to review it.
(Located at the Reception Desk)

Print Patient Name _____ Date_____

Patient Signature_____ DOB_____