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New Patient Forms

Foot & Ankle Clinics of Arizona

Patient Information - Informacion del paciente

Please bring the following to your appointment; Insurance Card (Tarjeta de aseguranza), Photo ID (Identificacion), Medication List (Lista de medicinas)

Name/Nombre: *

Date of Birth/ Fecha de nacimeinto: *

MM/DD/YYYY

SSN/ Numera de Seguro Social del paciente: *

Sex/Sexo: *

Home Address/ Direccion de la casa: *

City/Ciudad: *

State/Estado: *

Zip Code/Codigo postal: *

Cell Phone/ Telefono celular: *

Home Phone/Telefono de la casa: *

Email Address/Correo electronico:

Additional Information

Height/Altura:

Weight/Peso:

Race/Raza:*

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Hispanic
- ○ Native Hawaiian or Pacific Islander
- ○ White
- ○ Other
- ○ Decline

Parent or Guardian gurantor's insured name/Nombre del segurado del padre o tutor: *

Primary Care Provider (PCP)/ Proveedor de atencion primaria: *

Date of last visit/ Ultima fecha de visita:: *

MM/DD/YYYY

Parent or guardian guarantor's insured name/ Nombre del asegurado del padre o tutor:

Guardian's social security number/ Numero de seguro social del guardian:

Perferred Pharmacy/Farmacia preferida:

Crossroads/ Encrucijada:

Reason for today's visit/ Motivo de la visita de hoy:

Medical History

How long have you had these symptons? Desde cuando ha sufrido del estos sintomas?:

Have you seen anyone prior to this appointment?/Ha vista a alguien antes de esta cita?:

Have you had any prior foot surgery?/Ha tenido alguna cirugia en el pie?

If yes, please list and name of the procedure and date it occurred/ En caso afrimativo, por favor indique el nombre del procedimiento y la fecha en que ocurrio:

Do you have any X-rays, MRIs, or office notes? Tiene alguna radiografia previa, MRI or notas del la oficina?

Have you treated the pain in any way/ Ha tratado el dolor de alguna manera?:

Treatment:

- ☐ Medication/ Medicacion:
- ☐ Changed shoe type or size/ Tipo tamano de calado cambiado
- ☐ Stretching/Extension:
- ☐ Other/Orta:

How would you describe the pain/ Como describirias el dolor?

Pain:

- ☐ Deep aching/ Dolor profundo:
- ☐ Sharp, Shooting Pain/ Dolor agudo y punzante:
- ☐ Numbness/Burning/ Entumenciemiento/ Ardiente:
- ☐ Other/Orta:

Rate your level of pain/ Evalue su nivel de dolor:

- ○ 1 - No pain/Sin dolor
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 - Worst pain/ Peor dolor

Medication List/ Lista de medicamentos: *

Allergies/Alergias: *

- ☐ Adhesive Tape/Adhesivo o cinta
- ☐ Latex/Latex
- ☐ Aspirin/Aspirina
- ☐ Penicillin/Penicillna
- ☐ Local Anesthics/Asnestesicos locales
- ☐ Iodine Dye/ Tinte de yodo
- ☐ Sulfa drugs (Bactrim):
- ☐ Seafood/Mariscos:
- ☐ Morphine/Morfina:
- ☐ NSAIDS (Motrin, Alleve, Naprosyn, Ibuprofen)
- ☐ Codeine/Codeina:
- ☐ Other/Orta:
- ☐ None/Niguna:

Please check all that apply *

- ☐ Anemia
- ☐ Angina or Chest Pain/Angina o dolor en el pecho
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol/Colesterol alto
- ☐ Diabetes
- ☐ Asthma/Asma
- ☐ Depression/Depresion
- ☐ AIDS/HIV/SIDA/VIH
- ☐ Hypothyroidism
- ☐ Cancer
- ☐ Congestive heart failure (CHF)/ Insuficiencia cardiaca congestiva
- ☐ Coronary Artery Disease/Enfermedad de la arteria coronaria
- ☐ Chronic Obstrcutive Pulmonary
- ☐ Disease (COPD)/ Enfermedad pulmonar obstructiva cronica
- ☐ Gout/Gota
- ☐ Arthritis/Artritis
- ☐ Gastric ulcer/Ulcerta gastrica
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis/ Artrix reumatoide
- ☐ Hepatitis or liver disease/ Hepatitis o enfermedad del higado
- ☐ Kidney Disease/ Enfermedad del rinon
- ☐ Drug abuse disorders/Trastornos del abuso de drogas
- ☐ Deep vein thrombosis (DVT)/ La trombosis venosa profunda
- ☐ Thyroid Disease/Enfremedad de tiroides
- ☐ Dialysis/Dialisis
- ☐ Peripheral arterial disease/ Enfermedad arterial perferica
- ☐ Heart Attack/ Ataque al corazon
- ☐ Lymphedema/Linfedema

Type of Cancer

(If Applicable)

Other

(If Applicable)

Social History

Are you pregnant/ Estas embarazada?

Are you nursing/Esta usted amamantando?

Do you smoke? *

-- Please Select --

How frequently?

- ☐ Everday/Cada dia:
- ☐ Some days/algunos dias:
- ☐ Formerly/Antes:
- ☐ Never/Nunca:
- ☐ Frequency unknown/ Frecuencia Desconocida:

(If Applicable)

Any other forms of tobacco?

-- Please Select --

List

(If Applicable)

Do you drink alcohol?

-- Please Select --

How often?

(If Applicable)

Do you use any illicit drugs?

-- Please Select --

List

(If Applicable)

Family History

Does anyone in your family (living or deceased) have the following:

Please check all that apply

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Stroke
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Depression
- ☐ Mental Illness
- ☐ Hypothyroidism

Other

Surgical History

Please select/list all surgeries:

Please check all that apply:

- ☐ Appendix
- ☐ Tonsils/Adenoids
- ☐ Hysterectomy
- ☐ Gallbladder
- ☐ C-Sections
- ☐ Heart

Financial Responsibility:

I am aware that benefits are determined by my insurance company and not by the provider. Verification of benefits is not a guarantee of payment, and I will be responsible for any portion of my treatment that is not covered or is denied by the insurance company including my co-payments, deductibles, and co-insurance. I understand that all co-pays and service charges that are not covered by my insurance company will be due at the time of service. I understand the provider is not responsible for the misquotation of benefits from my insurance company. Insurance benefits are determined by my insurance company when the claim is received. I hereby authorize Foot and Ankle Clinics of Arizona to release any information, for insurance purposes, required in the course of my examination or treatment. I hereby authorize payment directly to Foot and Ankle Clinics of Arizona for treatment, if any, otherwise payable to me for services. I understand that I am responsible for all charges if it is determined that the insurance information that I have provided is incorrect. I understand that there will be a $20.00 service charge on all returned checks.

HIPAA / RECORDS AUTHORIZATION:

1, the undersigned understand I have a right to review, if I choose to, Foot and Ankle Clinics of Arizona, Notice of Privacy Practices prior to signing this document, which are available upon request or on our website, yourfeetfixer.com. The privacy of your medical records and personal information is important to us, Documentation of your medical treatment and services rendered are created to provide you with quality care and to comply with certain legal requirements (HIPAA guidelines). Our legal duty is to keep your medical information private and to comply with the terms and conditions of the current notice. We may disclose information for treatment, payment, or to healthcare personnel for the purpose of the quality of your care, and to obtain any authorizations, precertifications, etc. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information. Any information you do not wish to disclose must be specified in writing. Any information being requested to be released to anyone besides a referring or treating physician must be submitted to us in writing.

Consent for Treatment:

I have read and understand the statements above, I give my permission to the doctor(s) of Foot and Ankle Clinics of Arizona to administer and perform procedures as may be deemed necessary to the diagnosis and/or treatment of me or my dependents' condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment at Foot and Ankle Clinics of Arizona.

Signature:

Clear

New Patient Forms will be submitted to **Foot and Ankle Clinics of Arizona**

Submit

*You have **18** required fields to fill out. Click here to show them.*