Arizona Foot & Ankle

Medicine & Surgery

Dr. Blair J. Sandall D. P. M

Patient Name:______________________________________Date:__________________

E-Mail Address: ____

Please Describe Current Foot Issues

____

____

Have you had treatment for this issue? ☐ Yes ☐ No (What treatments if any?) ________________

____

What activities do you participate in? ☐ Sports ☐ Aerobics ☐ Biking ☐ Hiking ☐ Running ☐ None

Height:____________Weight:___________Shoe Size:__________Do you drive a car ☐ Yes ☐ No

Occupation: ____________________How did you hear about us? ____________________

Tobacco use: ☐ Never ☐ Cigarettes ☐ Cigar ☐ Chew # Years____Packs/Day _______Quit: ________

Alcohol Use: ☐ Never ☐ Liquor-Frequency:_______________ ☐ Beer-Frequency: ______________

Other Drugs: ☐ Never ____

PERSONAL & FAMILY HISTORY

Please check appropriate box.

	Personal	*Family*	*If yes, Indicate date & or relationship*
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	
Gout	☐ Yes ☐ No	☐ Yes ☐ No	
Lung Disease	☐ Yes ☐ No	☐ Yes ☐ No	
Liver Disease	☐ Yes ☐ No	☐ Yes ☐ No	
HIV	☐ Yes ☐ No	☐ Yes ☐ No	
Rheum Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	
Vision Problems	☐ Yes ☐ No	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No	
Stomach Ulcers	☐ Yes ☐ No	☐ Yes ☐ No	
Skin Disorders	☐ Yes ☐ No	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	
Bleeding Issues	☐ Yes ☐ No	☐ Yes ☐ No	
Sickle Cell	☐ Yes ☐ No	☐ Yes ☐ No	

Allergies & type of Reaction: ____

Antibiotics and Pain Medications used in the past: ____________________________

Current Medications: (attach list if you have one)

Drug	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Past Surgeries & Hospitalizations & Dates

Most recent 1st	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

ARIZONA FOOT AND ANKLE MEDICINE AND SURGERY PLC

1347 N GREENFIELD Rd STE #101 MESA, AZ 85205 PH: (480)699-8762 FAX: (480)699-8350

Patient Information

Last Name, First MI	Social Security #	Date of Birth	Age	Sex M F
Current Address	Permanent Address (If Applicable)			
City, State, Zip	City, State, Zip			
Current Phone #	Cell Phone #			
Status: Single Married Widowed Divorced Separated	Emergency Contact	Relationship	Phone #	

Referral Information

Referring Medical Provider Name	Referring Phone #
Primary Care Doctors Name	Primary Care Doctor Phone #

Employment Information

Employment Status: FT PT Disabled Retired Other________________________ Student Status: FT PT N/A

Current Employer Name		Employer Address
Occupation	Work Phone #	City , State, Zip

Responsible Party Information

Name	SSN	Date of Birth
Address	Employer Name	
City, State, Zip	Work Phone#	
Phone #	Relationship to Patient: **SELF** Spouse Child Other____________	

Attorney Information (If being seen for injury being claimed in a lawsuit)

Attorney Name	Address
Firm Name	City, State, Zip
Case #	Phone #

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my insurance benefits to be paid directly to the provider for services rendered. I understand my provider will bill my insurance on my behalf, but that I am financially responsible for all charges whether or not they are covered by insurance. I understand if I fail to fulfill my financial responsibility and my account is referred to outside collections, there will be a collection fee of up to **35%** added to my outstanding balance. I understand I will be charged a **$50.00** fee for any missed appointment which I failed to cancel or reschedule at least 24 hours in advance. I also understand that it is my responsibility to obtain information from my insurance on whether procedures and treatments will be covered or not. I hereby authorize the release of all information necessary to secure the payment of benefits owed.

Responsible Party Signature	Date

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Insurance Information

(If your visit today is Related to work, auto, or third party liability injury, please complete the information requested in the last section of this form entitled "Other Insurance Information".)

Primary Insurance Name	Subscriber ID #	Group #
Claims Address	Subscriber Name	
City, State, Zip	Subscriber Social Security #	Subscriber Date of Birth
Insurance Phone #	Relationship to Patient: **SELF** Spouse Child Other___________________	

Secondary Insurance

Secondary Insurance Name	Subscriber ID #	Group #
Claims Address	Subscriber Name	
City, State, Zip	Subscriber Social Security #	Subscriber Date of Birth
Insurance Phone #	Relationship to Patient: **SELF** Spouse Child Other___________________	

Tertiary Insurance

Third Insurance Name	Subscriber ID #	Group #
Claims Address	Subscriber Name	
City, State, Zip	Subscriber Social Security #	Subscriber Date of Birth
Insurance Phone #	Relationship to Patient: **SELF** Spouse Child Other___________________	

Other Insurance Information

(This section is for Work, Auto, and Third party Liability Injuries)

Services Related to: Auto Accident Work Related Other______________	Type of Injury	Date of Injury
If Work Related, Employer at time of Injury	Insurance Name	
Employer Address	Claim Address	
City, State, Zip	City, State, Zip	
Employer Phone #	Claim #	
Employer Policy #	Claim Adjuster Name	Phone #
If Auto or Other Related, Policy Holder Name	Policy Holder Policy #	

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Our office is concerned about your right to privacy as it relates to your health care and treatment. Our office adheres to and complies with the 1996 HIPAA Compliance Regulations.

ACKNOWLEDGEMENT *OF RECEIPT OF PRIVACY NOTICE*

I acknowledge that Arizona Foot and Ankle Medicine and Surgery PLC's Notice of Privacy Practices has been made available to me.

____ ____________________________

Patient, or legally authorized individual, signature *Date*

____ ____________________________

Printed Name, ***if signed on behalf of the patient*** ***Relationship*** *(parent, legal guardian, personal representative, etc)*

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CONSENT TO PHOTOGRAPH

This consent is to be used for photographs taken in the course of medical treatment and will be used expressly for that purpose and within the scope of permitted health care operations. Photography for other purposes (e.g. research, publications, outside education, marketing, public relations, news or documentary) will not be permitted unless expressly permitted below.

The undersigned herby consents to be photographed while receiving treatment by **ARIZONA FOOT & ANKLE MEDICINE & SURGERY, its Doctors, employees or affiliates**. This is with the understanding that the photos will be used for/as:

Initial Below

☐ ______________ 1. Research
☐ ______________ 2. Insurance Authorizations
☐ ______________ 3. Publications
☐ ______________ 4. Outside Education
☐ ______________ 5. Marketing
☐ ______________ 6. Public Relations
☐ ______________ 7. News or Documentary
☐ ______________ 8. Treating Physician Deems Appropriate

☐ The use of any photograph or video is subject to these limitations:

____
____
____

The Term "Photograph" or "Photos" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

DATE:________________________TIME:__________________________AM/PM

Signature:_________________________Printed__________________________

Relationship:____
Patient/Parent/Guardian etc.

Witness:___________________________Printed__________________________

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