

## PATIENT INFORMATION

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Sex: M F Marital Status: S M W D

Occupation \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ How Long? \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Spouse \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

### MEDICAL INSURANCE

Company Name \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

Other Insurance (if any) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### Physician Disclosure:

Arizona law requires a physician to disclose to a patient those arrangements permitted under applicable Arizona law whereby such physician has a direct financial interest in a separate diagnostic or treatment agency, or in non-routine goods and services for which the patient is being referred. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to its affiliated entities, for certain services, such as physical and occupational therapy, orthotics and durable medical equipment, medical imaging, pharmacy, laboratory, and other diagnostic and treatment modalities, and that these treatments or services are available on a competitive basis.

Accordingly, I hereby acknowledge that my attending physician(s) disclosed to me, at the time of

initial contact and at the time of referral (i) his or her affiliation, if any, with the affiliated entities for whom, I, the patient am being referred, and (ii) that he/she may receive, directly or indirectly, remuneration for the referral to such services provided by these entities. I understand that I, the patient, have the right to choose the providers of my health care services and/or products and, as such, I have the option of receiving services from any service provider that I choose.

I hereby give permission to Steven A. Burns, D.P.M. and his associates or assistants, to administer treatment as may be deemed necessary in the diagnosis and treatment of my foot condition.

Assignment: I authorize the release of information necessary to process this claim and hereby assign my insurance benefits to be paid directly to Footcare Physicians of Scottsdale, PLLC.

\_\_\_\_\_ Date \_\_\_\_\_ Signature

**Medical History:**

Diabetes	___NO___YES
Lung Disease	___NO___YES
Rheumatoid Arthritis	___NO___YES
Hypertension	___NO___YES
Liver Disease	___NO___YES
Osteoarthritis	___NO___YES
Heart Disease	___NO___YES
Hepatitis	___NO___YES
Fibromyalgia	___NO___YES
Gout	___NO___YES
Ulcers	___NO___YES
Infectious Disease	___NO___YES
Bleeding Problem	___NO___YES

**Allergies:** \_\_\_None \_\_\_Aspirin \_\_\_Penicillin \_\_\_Sulfa \_\_\_Local anesthetic  
\_\_\_Cortisone \_\_\_Tape \_\_\_Iodine \_\_\_Other \_\_\_\_\_

**Tobacco:** \_\_\_No\_\_\_Yes Amt.\_\_\_\_ **Alcohol:** \_\_\_No\_\_\_Yes Amt.\_\_\_\_\_

Do you currently have any addiction problems or have you ever been treated for substance abuse?  
\_\_\_No \_\_\_Yes

**Prior Footcare:** \_\_\_No\_\_\_Yes **Date:**\_\_\_\_\_ **Dr.**\_\_\_\_\_

**Current Medications:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Surgeries/Hospitalizations:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices:**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose so) and understood the notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative  
(if applicable)

\_\_\_\_\_  
Signature

## Review of Systems

X Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Please check any illness, symptoms or problems that you have had:

### **Constitutional**

- Blood Pressure
- Respiration
- Fever/sweats
- Fatigue
- Loss of appetite/weight change

### **Eyes**

- Eye Disease of injury
- Eye glasses/contact lenses
- Blurred/double vision
- Glaucoma

### **Ears / Nose / Mouth / Throat**

- Hearing loss
- Hearing noises in your ear
- Earaches and drainage
- Nosebleeds
- Trouble swallowing
- Bleeding gums
- Sore throat
- Snoring
- Voice changes
- Problems with thyroid

### **Musculoskeletal**

- Joint pain/stiffness
- Muscle pain/cramps/weakness
- Back pain

### **Skin**

- Rashes
- Lesions
- Ulcers

### **Cardiovascular**

- Chest pain/angina
- Palpitations
- Shortness of breath
- Swelling of feet, ankles or hands
- Murmur

### **Respiratory**

- Cough
- Spitting up blood
- Shortness of breath
- Wheezing

### **Gastrointestinal**

- Problems with bowel movements
- Nausea/vomiting
- Rectal bleeding/blood in stool
- Abdominal pain/heartburn

### **Genitourinary**

- Flank pain
- Problems with urination
- Blood in urine
- Kidney stone

### **Neurological**

- Headaches
- Numbness/tingling sensations
- Tremors
- Head injury

### **Hematologic/Lymphatic**

- Slow to heal after cuts
- Tendency to bleed/bruise
- Blood clots
- Past blood transfusion

### **Other Symptoms**

- Memory loss/confusion
- Nervousness/anxiety
- Depression
- Insomnia

None Apply

X Completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_ X Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ X Date: \_\_\_\_\_