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:_____