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/Financial Policy:

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.

In the event patient financial responsibility becomes delinquent, I agree to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

_____ _____

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

Communications Consent Form

In order for us to best service your account or to collect any amounts due, we may utilize a third-party vendor who may contact you by telephone at telephone numbers associated with your account, including wireless telephone numbers, which could result in charges to you. We, or any third-party vendor authorized by us, may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
I have read this disclosure and agree that I may be contacted as described above.

These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended.

Signature (Date)

Review of Systems

PATIENTS: PLEASE CIRCLE ALL CONDITIONS THAT APPLY

Constitutional

Blood Pressure

Respiration

Fever/Sweats

Fatigue

Loss of Appetite/Weight Change

Eyes

Eye Disease or Injury

Eye glasses/contact lenses

Blurred/Double Vision

Glaucoma

Ears/Nose/Throat/Mouth

Hearing Loss

Hearing Noises

Earaches and/or Drainage

Nosebleeds

Difficulty Swallowing

Bleeding Gums

Sore Throat

Snoring

Voice Changes

Problems with Thyroid

Musculoskeletal

Joint Pain/Stiffness

Muscle Pain/Cramps/Weakness

Respiratory

Cough

Spitting up Blood

Shortness of Breath

Wheezing

Gastrointestinal

Problems with bowel movements

Nausea/vomiting

Rectal Bleeding/ Blood din Stool

Abdominal Pain/Heartburn

Genitourinary

Flank Pain

Problems with Urination

Blood in Urine

Neurological

Headaches

Numbness/Tingling Sensations

Tremors

Head Injury

Hematologic/Lymphatic

Slow to Heal After Cuts

Tendency to Bleed/Bruise

Blood Clots

Back Pain

Skin

Rashes

Lesions

Ulcers

Cardiovascular

Chest Pain/Angina

Palpitations

Shortness of Breath

Swelling of Feet, Ankles or Hands

Murmur

Past Blood Transfusion

Other Symptoms

Memory Loss/Confusion

Nervousness/Anxiety

Depression

Insomnia

CIRCLE IF NONE APPLY

_____Date:_____

Patient Signature (or Authorized Representative)

_____Date:_____

Medically Reviewed By: