PREMIER FOOT & ANKLE
SCOTT PRICE D.P.M.
PATIENT INFORMATION

First Name:_____ **MI:** _____ **Last Name:** _____ **Birthdate:**_____

Gender: **Male** **Female** **Social Security Number:**_____ **Email:**_____

Mailing Address:_____ **City:** _____ **State:** ____ **Zip:**_____

Primary Phone:_____ **Secondary Phone:**_____ **Work Phone:**_____

Primary Care Physician:_____ **Date Last Seen:**_____

Ethnicity: ☐ I decline to answer ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Language: ☐ I decline to answer ☐ English Other_____

Race:
☐ I decline to answer
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White

Marital Status: Married Divorced Legally Separated Partner Widowed Single

Student? Full Part Not **Retired?** Yes No **Employment?** Full Part Not

Employer Name:_____

How did you hear about Dr Price?_____

Spouse or Parent Name:_____

Emergency contact name:_____ **Relationship:**_____ **Phone#:**_____

Referring Physician:_____ Pharmacy:)_____

Medical Insurance Information

Primary:_____ **Secondary:**_____

Policy/id#:_____ **Policy/id#:**_____

Group#:_____ **Group#:**_____

Policy Holder Name:_____ **Policy Holder Name:**_____

Policy Holder or Responsible Party Information

☐ **Self (Go to the next Section If You Checked Self)** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Name:_____ **Date of Birth:**_____ **Gender:** **M** **F**

Mailing Address:_____ **City:** _____ **State:** _____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____

Employer Name:_____ **Social Security #:**_____

PLEASE TURN OVER

Patient Name:_____ **Birthdate:**_____

Describe your foot/ankle problem:_____

Please circle foot/ankle that is bothering you: Left Right Both

How long has it been bothering you?_____

Nature of problem (please mark any that apply):

___Aching ___Burning ___Painful ___Swollen ___Tender ___Throbbing
___Tingling
___Blistering ___Reddened ____Infected ____other_____

Problem occurred: (please mark any that apply):

___Acute ___Insidious ___Non Traumatic ___Slowly ___Sudden ___Traumatic

The problem is

___Worsening ___Unchanged ___Improving ___exacerbating and remitting

The problem is worse when:

___Standing ___bed rest ___cold weather ____exercising ___driving ____wearing shoes
___walking ___ Other_____ ___Nothing that I am aware of.

Previous treatments include:

___cortisone injection ___Custom orthotics ___OTC inserts ___Eval by another Doctor ___Ice
___rest ____Stretching exercises ___New Shoes ___Anti-inflammitories ___Lotions ___Soaks
___Other:_____

On a pain scale of 1-10 10 being the worst please rate your pain or discomfort level at its worst: (circle answer below)

No Pain or discomfort, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

List any problems you have had with your feet in the past_____

List any past surgical procedures you have had on your feet/ankles:_____

Have you ever seen Dr. Price in the past?_____

Do you have Diabetes? _____ Type 1 or 2? _____How many years diagnosed as diabetic?_____

Is your diabetes well controlled?_____ Last A1c_____Average blood sugars?_____

In order to make communications concerning appointments, treatment and billing matters easier, law requires your consent to release personal and health information.

Please list specific names of family members and/or friends that have your permission to obtain information from this office regarding your care and personal information.

Name: _____ Relationship _____ Name _____ Relationship _____
Name: _____ Relationship _____ Name _____ Relationship _____

May we leave test results in messages? ☐ **Yes** ☐ **No**

I give my permission to leave a message on my: ☐ Home answering machine ☐ Cell phone ☐ Work Voicemail ☐ E-mail

Please provide email address you would like your visit summaries sent to:_____ **OR**

_____ _____

PATIENT/PARENT OR LEGAL GUARDIAN SIGNATURE DATE

Premier Foot & Ankle, Scott Price
Medical Information
(Please fill out completely)

Patient Name:_____ **Birthdate:**_____

Past Medical History

Please✓ mark any conditions below that you are currently being treated for OR have been treated for **in the past**

☐ AIDS/HIV	☐ Cancer	☐ Hepatitis	☐ Polio
☐ Alcoholism	☐ Chicken Pox	☐ Herpes	☐ Rheumatic Fever
☐ Allergies	☐ Diabetes	☐ High Blood Pressure	☐ Stroke
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple Sclerosis	☐ Thyroid Disorders
☐ Asthma	☐ Epilepsy	☐ Pacemaker	☐ Tuberculosis
☐ Birth Trauma	☐ Gout	☐ Pneumonia	☐ Ulcers
☐ No Significant Past Medical History		☐ Other(List all other medical History)_____	

Personal Medical

Please ✓ Mark any symptoms/conditions below that you are currently experiencing

___Chills	___Itchy Skin	___Weakness	___Cuts take longer to heal	___Stroke
___Dizziness	___Lower leg ulcers	___Anesthesia	___Hyperglycemia	___Tightness in chest
___Fever	___Non-healing wound	___Neurological symptoms	___Unexplained weight loss	___Varicosities
___Frequent headaches	___Excessive scar tissue	___Numbness	___Unusual Fatigue	___Bleeding or lymph node problems
___Nausea and Vomiting	___Hypertrophic scars	___Paralysis	___Asthma	___Bruise easily
___Blurred Vision	___Tinea Pedis	___Paresthesia	___Other breathing problems	___Calf Pain
___Light Sensitivity	___Other skin condition	___Seizures	___Shortness of breath	___Inability to stop bleeding
___Watery Eyes	___Allergic or immunologic	___Stocking and glove numbness	___Blood in stool	___Swelling
___Difficulty with swallowing	___Arthritic flare up	___Tingling	___Diarrhea	___Swollen Groin Lymph nodes
___Diminished hearing	___Gouty attack	___Tremors	___Anemia	___Water retention
___Tinnitus	___Back Pain	___Blood in urine	___Ankle Swelling	___Addiction to alcohol
___Athletes foot	___Heel Pain	___Currently pregnant	___Calf Cramping	___Addictive tendencies
___Blisters	___Joint Redness	___Frequent Urinary infections	___Change in color of extremity	___Anxiety
___Burning of skin	___Joint swelling	___Impotence	___Congestive heart failure	___Depression
___Dermatitis	___Leg cramps	___Painful Urination	___Elevated Blood pressure	___Psychiatric or emotional difficulties
___Dry Scaly Skin	___Morning stiffness	___STD	___Heart Palpitations	___Suicidal thoughts
___Eczema	___Muscle tenderness	___Bronzing of skin	___Loss of sensation	
___Psoriasis	___Osteoarthritis	___Diabetes type 1	___Myocardial Infarction	
___Rash	___Rheumatoid arthritis	___Diabetes type 2	___Phlebitis	

☐ No Current symptoms/conditions ☐ Other: (please list other problems)_____

Family History

Please ✓mark any conditions below that apply to your family history **(circle Mother, Father or write in other)**

☐ Allergy	Mother	Father	Other:_____	☐ Heart Disease	Mother	Father	Other:_____
☐ Atherosclerosis	Mother	Father	Other:_____	☐ Hypertension	Mother	Father	Other:_____
☐ Cancer	Mother	Father	Other:_____	☐ Melanoma	Mother	Father	Other:_____
☐ Cardiovascular Disease	Mother	Father	Other:_____	☐ Osteoarthritis	Mother	Father	Other:_____
☐ Diabetes Type I	Mother	Father	Other:_____	☐ Psoriasis	Mother	Father	Other:_____
☐ Diabetes Type 2	Mother	Father	Other:_____	☐ Rheumatoid Arthritis	Mother	Father	Other:_____

☐ No remarkable family History ☐ Other: (Please list other family history)_____

Surgical History

List past Surgeries:_____

☐ No remarkable past surgery

Social

Who do you live with?_____

Do you drink caffeinated beverages (cola, coffee, or tea)?_____ Number per

Drink Alcohol? ☐ No ☐ Yes If yes, how many drinks per day/week?_____

Use of Illegal Drugs? ☐ No ☐ Yes ☐ Only in the past

PLEASE TURN OVER

Premier Foot & Ankle
Scott Price D.P.M.

Patient Name: _____ **Date of Birth:** _____

Weight: _____ **Height:** _____ **Shoe Size:** _____

MEDICATIONS:

☐ I do not take any medications, supplements or herbs.

Medication/supplement/herb	Dosage	Frequency	Route of administration (circle one)
			Oral IV Injection Suppository Other :
			Oral IV Injection Suppository Other :
			Oral IV Injection Suppository Other :
			Oral IV Injection Suppository Other :
			Oral IV Injection Suppository Other :
			Oral IV Injection Suppository Other :
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ALLERGIES: List all allergies to Medications: _____

Do you have any problems taking Aspirin, Ibuprofen or other Anti-Inflammatories? (Please Specify) _____

Are you allergic to: (Please Circle yes or no)

Tape? Yes No

Latex? Yes No

Betadine(Iodine)? Yes No

Novocaine? Yes No

SMOKING STATUS?

☐ Never a Smoker

☐ Former Smoker
Start Date: _____
End Date: _____

☐ Current Every Day smoker
Start Date: _____
How much do you smoke per day? _____

☐ Current some days smoke
Start Date: _____
How much do you smoke pe day? _____

Month and year of your last Flu (influenza) shot _____

Have you ever received a pneumonia Vaccine? Yes No

Have you had 2 or more falls with injury in the last 12 months? Yes No

Do you take medication to control blood pressure? Yes No

_____ Initials

_____ Date

AUTHORIZATION TO PAY AND INSURANCE RELEASE AUTHORIZATION:

I hereby authorize Dr. Scott Price to furnish my insurance carrier with all information concerning my present illness or injury. I authorize all benefits under this claim to be paid directly to Premier Foot & Ankle. I understand that I am financially responsible for any and all charges that are not covered.

I authorize Premier Foot & Ankle to release any medical or incidental information that may be necessary for either medical care or in processing applications for medical benefits. I certify that the information given by me in applying of payment is correct. I authorize release of all records on request. A photocopy of these assignments shall be valid as the original. My signature remains in effect until revoked by my writing.

PATIENT/PARENT OR LEGAL GUARDIAN SIGNATURE:_____ **DATE:**_____

I consent to photography for the purpose of documentation_____
Initials

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Premier Foot & Ankle for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE:_____ **DATE:**_____

FINANCIAL POLICY

Insurance and Payments

Your insurance is a contract between you (sometimes through your employer) and the insurance company. It is very important that you understand the provisions, benefits, and restrictions of your policy. While the filing of insurance claims is a "courtesy" that we extend to our patients, all charges are your responsibility. We cannot guarantee payment of claims from your insurance company. Also, having a secondary insurance does not guarantee that your services are covered 100% nor does reduction or rejection of your claim by your insurance company relieve you of your financial obligation with our practice. Please remember that professional medical services are rendered and charged to the patient not to the insurance company. Our practice fees are considered to fall within the usual and customary range of most insurance plans. Your payment for co-payments, non-covered services and deductibles are due the day of service. Our office accepts cash, checks, Visa, Discover, and MasterCard for your convenience. A charge of $15.00 is assessed on returned checks, and no appointments can be scheduled until the matter is resolved.

If your insurance company has not paid your account in full within 90 days, the balance will be transferred to the patient for payment. We realize that personal circumstances may arise that may affect timely payment of your account. If this situation occurs, or where a claim is pending, or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated.

Please notify our office as soon as possible if you have any changes in your insurance company, policy number, or coverage. This will help us keep your information current, and it will assist in prompt insurance payments to your account.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY

PATIENT/PARENT OR LEGAL GUARDIAN SIGNATURE:_____ **DATE:**_____

PLEASE TURN OVER

Premier Foot & Ankle LLC
3149 N Windsong Dr
Prescott Valley, AZ 86314
Phone: 928-772-5916
Fax: 928-775-3250

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

_____ _____
Patient Name **Date**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Premier Foot & Ankle may use or disclose my protected health information for treatment, payment or healthcare operations—which means for providing health care to me, the patient; handling billing and payment ;and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Premier Foot & Ankle has a detailed document called the '***Notice of Privacy Practices***'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Premier Foot & Ankle will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Premier Foot & Ankle to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to extent that Premier Foot & Ankle has taken action relying on this consent.

_____ _____
Signature (Patient or Legal Custodian/Authorized Representative) **Date**

_____ _____
Signature (Patient or Legal Custodian/Authorized Representative) **Date**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Premier Foot & Ankle, 3149 N Windsong Dr, Prescott Valley, AZ 86314.