SOUTHWEST
FOOT & ANKLE

Patient Information:

First Name:_____ Middle Initial:_____ Last Name:_____

Date of Birth:_____ Gender: Male Female SSN:_____- _____-_____

Address: _____ City:_____ State:_____ Zip Code: _____

Phone Number: (____)-_____ Cell Phone: (____) -_____

Email Address: _____

Marital Status: Single Married Divorced Widowed Other

Height:_____ Weight:_____ Shoe Size:_____

Race: White Hispanic Asian Black/African American American Indian Other Decline

Ethnicity: Not Hispanic Hispanic/Latino Other Decline

Employment Information:

Employer:_____ Job Title:_____

Address: _____ City:_____ State:_____ Zip Code: _____

Phone Number: (____)-_____

Employment Status: Full Time Part Time Retired Self Employed Unemployed

Emergency Contact:

Name:_____ Relationship:_____

Phone Number: (____)-_____

Insurance Information:

Primary Policy:

Insurance Carrier:_____
ID/Policy Number: _____
Name of Policy Holder:_____
Date of Birth of Policy Holder:_____

Secondary Policy:

Insurance Carrier:_____
ID/Policy Number:_____
Name of Policy Holder:_____
Date of Birth of Policy Holder:_____

Visit Reason:

Why are you seeing us today?_____

Is there pain associated with this condition?

YES NO

If so on a scale of 1-10 what would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10

What causes or aggravates the pain?_____

_____

What works best to relieve the pain?_____

_____

Any additional factors you would like to mention?_____

_____

Whom may we thank for your referral?**:**_____

Primary Care Provider (PCP):

Who is your primary care provider?:_____

Date of last PCP visit ?_____ Pharmacy Information:_____

Allergies:

1. Please Indicate all allergies to medications:
   - **O** NO Known Drug Allergies

Medication:_____
Reaction: _____

Medication:_____
Reaction: _____

Medication:_____
Reaction: _____

Other Allergies: Adhesives Bandaids/Tape Gloves Latex

2. Do you have any complications due to Anesthesia? Yes No
   IF yes describe_____

Medications:

Medication:	Dose:	Frequency:

Medical History:

Constitutional/General
Cancer/Type:_____
Elevated Temperature
Night Sweats

Cardiovascular
Angina
Blood clots/DVT
Easy Bruising/ Bleeding
Heart Attack
Hypertension
Irregular Heart Beat
Poor Circulation
Rheumatic Fever
Valve Problems

Infectious Disease
HIV/AIDS
Tuberculosis/TB

Hematologic Disease
Anemia Type_____
Sickle Cell

Gastrointestinal
Acid Reflux/GERD
Gallbladder
Hiatal Hernia
Irritable Bowel Syndrome
Stomach/Bowel Problems
Ulcer

Genito-Urinary
Bladder or Kidney Stones
Kidney Failure
Dialysis
Prostate Disease

Endocrine
Heat/Cold Intolerance
Diabetes & Type:_____
Hyperthyroid
Hypothyroid

Vision
Double/Blurred Vision
Glaucoma
Hearing Deficit/ Loss
Hearing Aid
Macular Degeneration
Vision Change
Contacts/Glasses

Nervous System
Anxiety
Depression
Convulsion/Epilepsy
Fainting
Memory Loss
Migraines
Muscle Weakness
Muscle Dystrophy
Muscular Sclerosis
Stroke
Neuropathy
Parkinson's Disease
Other_____
_____

Social History:

1. Do you currently smoke or chew tobacco? Yes No
   How many packs per day?_____ How many years?_____
   If NO, have you in the past?_____ How many years?_____

2. Do you drink alcohol? Yes No How many glasses/drinks per day?_____

3. Do you drink caffeine? Yes No How many glasses/drinks per day?_____

4. Do you use any illicit drugs (i.e marijuana, cocaine, heroin, etc.)? Yes No
   If yes, which drugs?_____ If not, have you in the past years? Yes No

If yes, which drugs?_____

Surgical History:

Please list any surgeries AND years:

_____
_____
_____
_____
_____
_____

Family Health History:

Mother:_____
Father:_____
Siblings:_____
Children:_____
Maternal Grandparents:_____
Paternal Grandparents:_____

Financial Agreement
1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is furnished.
You are responsible for copays, deductibles, non-covered services, co-insurance and items considered "not medically necessary"
by your insurance company.
For unpaid claims over 45 days, it is your responsibility to follow up with you insurance and the balance due is considered due and
payable.
2. It is your responsibility to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified.
Patient Authorization
I hereby authorize Dr. Hugentobler to administer such medication or procedures as are necessary on the basis of findings in my case. I authorize the holder
of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related
insurance claim. I request that payment of authorized benefits by made to **Southwest Foot and Ankle, PC,** I agree to pay any charges incurred by me to
Southwest Foot and Ankle, PC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my
signature on all insurance submissions.
_____I authorize **Southwest Foot and Ankle, PC** to submit insurance claims using my signature on file below
_____I authorize the release of any medical information necessary in order to process this assignment on this claim.
_____I authorize payment of medical benefits to be paid directly to **Southwest Foot and Ankle, PC** for services described on the claim form.
ALL CO-PAYS AND/OR CO-INSURANCE ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.
Print Name
Signature Date