San Juan Foot & Ankle Center

Patient Information Sheet

Welcome to our office…

Please take a few minutes to complete the following form, as thoroughly as possible. Thank you.

Social Security#____-___-____ Patient Name (First) _____ (Last) _____

DOB: ___/___/___Age____ Sex__ Marital Status ____ E-mail: _____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home# _____ Work# _____ Other/Cell# _____

Employer _____ Occupation _____ Hours on feet _____

Primary Care Physician _____ Preferred Pharmacy_____

How did you learn of **SAN JUAN FOOT AND ANKLE** *please list name _____

Doctor ____ Friend ____ Relative ____Insurance Manual ____Other ____ Internet_____*please list site

Insurance Information

Medical Insurance: yes ____ no ____

A photo copy of your medical card(s) will be taken to obtain all necessary policy numbers & Photo ID

Parent/ Guardian/ Spouse Information

Name (First) _____ (Last) _____ Relationship Parent Guardian Spouse

Address _____ City _____ State ____ Zip _____

Phone Numbers: Home#_____ Work#_____ Other/Cell#_____

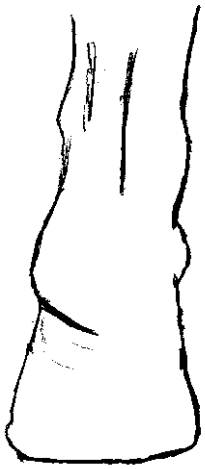
PLEASE READ CAREFULLY

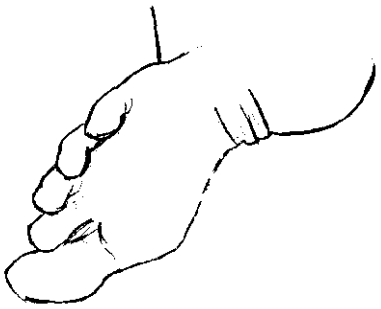
ANY UNPAID MONIES OWED FOR SERVICES RENDERED MAY BE REFERRED TO A THIRD PARTY COLLECTION AGENCY. THE AGENCY WE USE CHARGES 35% OF THE UNPAID BALANCE, DUE AT THE TIME IT IS TURNED INTO THEM. THOSE FEES BECOME YOUR RESPONSIBILITY, AS WELL AS THE PRINCIPLE BALANCE OWED. IN ADDITION TO COLLECTION COSTS AND INTREST, YOU WILL ALSO BE LIABLE FOR ALL ATTORNEY'S FEES AND COURT COSTS ASSOCIATED WITH LITIGATION RESULTING FROM NON-PAYMENT. _____(INITIAL)

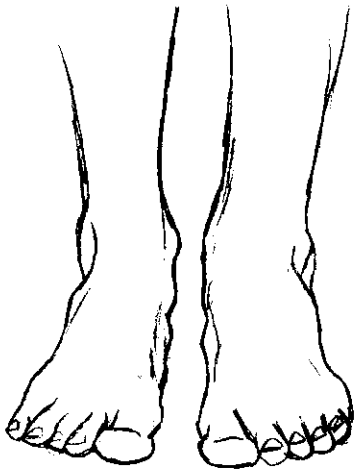
ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETE TO EPEDITE INSURANCE CLAIMS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED, UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. OFFICE VISITS AND PROCEDURES BILLED TO MY INSURANCE COMPANY AND NOT PAID WITHIN 60 DAYS BECOME THE RESPONSIBILITY OF THE PATIENT/GAURDIAN AT AN INTEREST RATE NOT EXCEED 19% ANNUM. PATIENTS WILL BE RESPONSIBLE FOR ANY AND ALL FEES ASSOCIATED WITH THE COLLECTION OF OUTSTANDING ACCOUNTS. I AUTHORIZE ***S.J.F.A.C.*** TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO THE DOCTORS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENEDENTS OR MYSELF. I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. **THE PATIENT WILL BE CHARGED $25 ($75-NEW PATIENT VISITS) FOR MISSED APPOINTMENTS** OR THOSE NOT CANCELLED WITHIN 24 HOURS, WITH CONSIDERATION OF CIRCUMSTANCES SUCH AS EMERGENCIES OR SICKNESS. THIS CHARGE IS NOT COVERED BY ANY INSURNACE PLAN. I AUTHORIZE TREATMENT FOR MY FOOT/ANKLE AND RELATED CONDITIONS.

I have received the Confidentially Agreement (HIPAA), as well as the payment agreement, and agree to comply with all its terms.

Today's Date: _____ Patient's Signature: _____







Please mark areas of concern with an X

Please describe the condition(s) in which you are here for today: _____

_____

Have you had this problem before? _____ **What solved it?** _____

When did this problem start? _____

What caused the problem? Circle One (trauma, over use, new activity, increased activity, new shoes)
Other: _____

What KIND of pain are you experiencing? Circle all that apply (throbbing, burning, aching, sharp, shooting, dull, discomfort, itching, cramping or catching**) Other:** _____

How bad is your pain on a scale from 1-10 (1 being the least, 10 being the worst) _____

What aggravates your problem(s)? Circle all that apply (walking, standing, direct pressure, shoes, sleeping, standing after rest, worsens with activity) **Other:** _____

Does anything alleviate your pain? (medications, ice, elevation, rest, narcotics, anti-inflammatories, shoes, orthotics)

Other: _____

Have you ever had medical treatment for this problem before? When/where/what? _____

_____

Are there any associated symptoms with your problem? Circle all that apply (redness, swelling, bruising, itching /discoloration, drainage, rash) **Other:** _____

Why does your problem concern you?_____

Please check the following if you have EVER experienced or had problems with:

Heart Attack	High Blood Pressure	Gout	Parkinson's
Heart Murmur	Multiple Sclerosis	Cholesterol	Cancer (type)
COPD	Osteoarthritis	Gastric Reflux	Blood Clot (where)
Cirrhosis	Rheumatoid Arthritis	Birth Defect	Glaucoma
Hepatitis (please specify)	Diabetes	Chronic Back Pain	Kidneys (please specify)
AIDS/HIV	Anxiety	Skin Disease	Rheumatic Fever
Liver	Depression	Arrhythmia	Stroke
Asthma	Seizures	Hypothyroidism	Ulcers (where)

Others:_____

Height:_____ Weight:_____

List ALL medications and supplements you are CURRENTLY taking:

_____

_____

List ALL allergies and reactions to medications:

_____

List ALL surgeries you have had, date of, complications, and any reaction to anesthetics:

_____

_____

How many cigarettes **do you/did you** smoke per day? _____ When did you start and/or stop? _____
How many alcohol drinks **do you/did you** have per week? _____
Do you/did you use any non-prescriptive drugs or IV drugs? _____

IMMEDIATE Family History of: (List who and what, and are they deceased from the condition)

Cancer: _____ High Blood Pressure: _____
Heart Condition: _____ Diabetes:_____
Foot or Leg Deformities: _____ Muscle or Bone: _____

Please check mark any of the following conditions **YOU** have **RECENTLY** experienced:

- CON:
- ☐ Fever
- ☐ Chills
- ☐ Nausea
- ☐ Vomiting
- ☐ Weight loss
- ☐ Weight gain

- Integ:
- ☐ Lumps
- ☐ Sores
- ☐ Rashes

- Head
- ☐ Dizziness
- ☐ Eye sight changes
- ☐ Headaches
- ☐ Problem Swallowing
- ☐ Ringing ears

- Resp:
- ☐ Problems breathing
- ☐ Pneumonia
- ☐ Asthma

- CV:
- ☐ Chest pain
- ☐ Chest tightness
- ☐ Heart palpitations
- ☐ Heart murmur

- GI:
- ☐ Abdominal cramping
- ☐ Bloody stools
- ☐ Diarrhea
- ☐ Stomach burning

- GU:
- ☐ Discharge
- ☐ Pain with urination

- M-skel:
- ☐ Broken bones
- ☐ Cramping
- ☐ Limb deformity

- Neuro:
- ☐ Loss of Consciousness
- ☐ Loss of use of any limb
- ☐ Blackouts
- ☐ Seizures

- Endo:
- ☐ Night sweats
- ☐ Excessive thirst
- ☐ Freq. night urination
- ☐ Excessive hunger

- Heme:
- ☐ Excessive bleeding
- ☐ Excessive bruising

- Psych:
- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness

Is there anything else the Doctor should know about your or your medical history?

_____

_____