PATIENT INFORMATION

Date _____

Last Name _____ First _____ Middle _____

Address _____

City _____ State _____ ZIP Code _____

(Is the billing address different than the above address? If yes, please note the billing address.)

_____

Telephone Numbers: Home _____ Work _____

Cellular _____ Email _____

Relationship to Guarantor on the account Self _____ Spouse _____ Child _____ Other _____

Patient's Birthday _____ Sex _____ Status: Single _____ Married _____ Other _____

Patient's Social Security #: _____ Referring/Family Physician: _____

Who may we contact in case of emergency? _____ Phone: _____

Who may we release information to? _____

INSURANCE INFORMATION

Date of injury or the date you noticed that your symptoms started _____

If this is an accident have you called your insurance company and reported the accident Yes No

If related to work, have you filed your workman's compensation papers? Yes No

PRIMARY INSURANCE NAME _____ Phone # _____

Address of Insurance Company _____

Place of employment: _____ Subscriber Name _____

Policy Number _____ Group # _____ Subscriber Birth date _____

Does your insurance company require a second opinion? Yes No

Does your insurance company require pre authorization for surgery and/or admission? Yes No

SECONDARY INSURANCE NAME _____ Phone # _____

Address of Insurance Company: _____

Place of Employment: _____ Subscribers Name: _____

Policy # _____ Group # _____ Subscriber Birth date _____

Recognizing the inherent risks of transmission of contagious diseases especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc, when deemed necessary by the physician/surgeon. Questions should be discussed with your physician. I herby authorize the attending physician to furnish the insurance company all information that the said insurance company may request from time to time. It b understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me or In the proper case to my employer or other provider of Insurance when my bill is paid in full. I .understand I am financially responsible to my physician and or surgeon for charges not covered by my insurance company. I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original cop in the doctor's flies and authorized the insurance company to accept the photocopy. I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
			Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
			Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

Surgeries you have had_____

_____

_____

Hospitalization other than for the surgeries listed_____

_____

_____

Family physician_____ Last visit date_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins_____

_____

_____

Pharmacy Name(s)_____

Pharmacy Phone(s)_____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature_____ Date_____

Mountain Crest FOOT & ANKLE

Timothy R. Black, D.P.M.
Complete Medical and Surgical Care of the Foot

1628 Elkcreek Drive
Idaho Falls, ID 83404
Phone: 208-528-8700
Fax: 208-528-2802

PATIENT_____ PATIENT GUARDIAN_____

ASSIGNMENT AND RELEASE

I hereby authorize Mountain Crest Foot and Ankle to obtain any necessary medical information from any facility or doctor that will help in my diagnosis and care. I authorize any insurance assignment/benefit be paid directly to Mountain Crest Foot and Ankle. I also authorize Mountain Crest Foot and Ankle to release any information to my insurance company in order to process my claim.

CONSENT FOR TREATMENT

I hereby authorize and request Mountain Crest Foot and Ankle to provide me with any and all necessary evaluations, therapies and/or treatments.

PROMISE TO PAY

I hereby agree to pay the full requested balance to Mountain Crest Foot and Ankle. I understand that insurance filings are done as a courtesy and do in no way release me from being responsible for accrued charges. I agree to pay all deductibles, co-pays, coinsurances, non covered services, any charges above "reasonable and customary" for insurance companies that we are not contractually bound, any and all claims that are denied for medical necessity or any other reason. I agree that I will pay the 18% interest fee that will begin to accrue after 60 days of said responsibility. I understand that the option exists of forming a payment plan with the billing staff of Mountain Crest Foot and Ankle. I am aware that my account may be turned over to a third party collection service if these terms are not kept, which may result in damaged credit, court costs, attorneys fees or garnished wages. I agree to pay the $20 collection filing fee if it is that my account is turned over to a third party collection service.
*Please note that follow-up visits are not free and will be billed to you and/or your insurance unless indicated otherwise by the Dr.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS IN THE ABOVE SAID POLICY.

X_____ Date: _____
Authorized Signature

PRIVACY PRACTICES

I acknowledge that I have read and signed our notice of privacy practices.

X_____ Date: _____
Authorized Signature

MEDICARE/MEDICAID AND MEDIGAP SIGNATURE AUTHORIZATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of authorized Medicare/Medigap government benefits made payable to Mountain Crest Foot and Ankle for any services furnished to me by the physician. (HCFA FORM CMS-1500 12-90). I also release any information needed from any source to the Health Care Financing Administration in order to determine correct benefits payable.

X_____ Date_____
Authorized Signature