

**Desert
Foot and Ankle, P.C.**

Desert Samaritan Medical Building III
1520 S. Dobson Road, Suite 307, Mesa, Arizona 85202
480-844-8218 Fax 480-844-9950
www.desertfootandankle.com

PATIENT REGISTRATION

Patient's Name _____ Patient's Age _____ Patient's Birthdate _____
 Billing Address _____ City _____ State _____ Zip _____
 Permanent Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work _____ Cell _____
 May we leave a message regarding medical care, billing, or other issues? () Yes () No
 Pt. Soc Sec # _____ Sex Male Female Status Married Single Other
 Responsible Party _____ Soc Sec # _____ Birthdate _____
 Primary Care Dr. _____ Address _____ Phone _____
 Who referred you? _____
 Full Time Student? Y N Employer Name _____
 In case of Emergency notify _____ Phone _____

INSURANCE INFORMATION

PRIMARY INS

SECONDARY INS

Ins Co. Name	Ins Co. Name
Eff. Date of Policy	Eff. Date of Policy
Policy Holder Name	Policy Holder Name
Relationship to Patient Birthdate	Relationship to Patient Birthdate
Policy Holder SSN#	Policy Holder SSN#

If you want us to bill your insurance for you, please give your insurance ID card(s) to the receptionist. If you do not have your insurance card(s), you are responsible to pay for services rendered at the time of service.

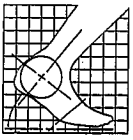
HMO policies only: I understand that I am responsible for obtaining my referrals from my primary care physician for each and every visit with this office. I understand that if I do not have the referral for my visit, or if I wish to waive the use of my referral under my HMO or insurance program, I am responsible for my balance.

I hereby authorize Desert Foot & Ankle PC to furnish information to my insurance carrier(s) concerning my examination and treatment, and I hereby assign to Desert Foot & Ankle PC all payments for Podiatric services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by my insurance.

I agree that this account will be "paid-in-full" upon presentation of the statement. Any courtesy fees are only extended predicated upon full-payment of fees at time of visit. If this account is not paid-in-full upon presentation of the statement, I agree to pay a monthly re-billing fee of \$3.00 per month until paid. In the event the account is turned over to an attorney or collection agency, I agree to pay any and all actual collection charges and/or attorney's fees incurred in an amount not to exceed 50% of the balance due. Interest of 18% per year will be accrued on the principal balance. I further agree that the jurisdiction for any action filed for the purpose of collection any sums due on this account shall be the place where the contract was made, specifically Maricopa County, Arizona. A photocopy or facsimile of this assignment shall be considered as valid as the original.

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 so chose) and understood the Notice.

Signature of Responsible party _____ Date _____



**Desert
Foot and Ankle, P.C.**

Desert Samaritan Medical Building III
1520 S. Dobson Road, Suite 307, Mesa, Arizona 85202
480-844-8218 Fax 480-844-9950
www.desertfootandankle.com

Patient's Name _____ Birthdate _____

Height _____ Weight _____ Shoe Size _____

Chief Complaint (reason for visit) _____

If Injury was it: Auto accident? Y N Work related? Y N Date of Injury _____

Medications: Prescriptions & Non-Prescriptions (include herbal remedies) I do not take any medications

NAME OF MEDICINE	DOSE	HOW OFTEN TAKEN

Past Accidents / Injuries _____

Please check "✓" if you currently have or if you have had a history of:

ALLERGIES	SURGERIES	YEAR	AUTOIMMUNE HISTORY
Adhesives	Appendectomy		Lupus
Anesthetics	Arthroscopy		Sarcoidosis
Antihistamines	Back		Scleroderma
Aspirin	Bladder		Other
Codeine	Breast L R		BLOOD DISORDERS
Darvon	Colon		
Demerol	Ears L R		Anemia
Iodine/Betadine	Eyes L R		Frequent Bruising
Latex products	Foot L R		Blood Transfusions
Mercurial	Gall Bladder		Leukemia
Merthiolate	Heart		Trouble Clotting Blood
Novacaine	Hernia		Other
Nylon/Plastic	Hip L R		CIRCULATORY HISTORY
Penicillin	Hysterectomy		
Seconal	Knee L R		
Sulfa	Neck		
Tetanus	Nose		
Tetracycline	Prostate		
Other	Shoulder L R		
	Tonsillectomy		Blood Clots
	Other		Hodgkin's Disease
			Legs/Feet Swelling
			Lymphoma
			Phlebitis
			Varicose Veins
			Vascular Disease
			Other
ANESTHESIA PROBLEMS? Y N			

Patient's Name _____ Date _____

Please check "✓" if you currently have or if you have had a history of:

CARDIAC HISTORY		GENITOURINARY		RESPIRATORY	
Angioplasty		Bladder Infections		Asthma	
Atrial Fibrillation		Blood in Urine		Bronchitis	
Chest Pain (Angina)		Dialysis		COPD	
Congestive Heart Failure		Kidney Problems / Stones		Chronic Cough	
Cholesterol Issues		Painful Urination		Emphysema	
Coronary Artery Disease		Prostate Problems		Hay Fever	
Heart Attack		Renal Failure		Pneumonia	
High Blood Pressure		Other		Shortness of Breath	
Irregular Heart Beat				Sleep Apnea	
Mitral Valve / Valve Problems		INFECTIOUS DISEASE		Tuberculosis	
Murmur		C-difficile		Valley Fever	
Pacemaker / Defibrillator		Fever Currently		Wheezing	
Cardiac Stents		HIV / AIDS		Other	
Other		Mononucleosis			
ENDOCRINE HISTORY		MRSA		REPRODUCTIVE	
Diabetes		Tuberculosis		Are You Pregnant?	
Hypoglycemia		Other		Endometriosis	
Thyroid Problems				Fibroids	
Unexplained Weight Loss		MUSCULOSKELETAL		Breast Feeding Currently	
Other		Arthritis Osteo / Rheumatoid		Other	
HEAD		Chronic Back Problems			
Blindness		Difficulty Opening Mouth		SKIN DISORDERS	
Cataracts L R		Fibromyalgia		Eczema	
Difficulty Swallowing		Gout		Psoriasis	
Deafness L R		Joint Pain		Rash Currently	
Glaucoma L R		Metal, Pins, Plates, Screws		Skin Cancer	
Hard of Hearing L R		Muscle Pain, Weakness		Skin Sores or Open Wound	
Head/Neck Injury		Polio		Trouble Healing Wounds	
Macular Degeneration		Other		Other	
Nose Bleeds					
Other		NEUROLOGICAL		SUBSTANCE USE	
GASTROINTESTINAL		Alzheimer's / Dementia		Alcohol Present / Past	
Cirrhosis / Liver Disease		Aneurysm		How Much?	
Colitis / Irr. Bowel Disease		Depression		Smoking Present / Past	
Colon Problems / Polyps		Head Injury		How Much?	
Crohn's Disease		Headaches / Migraines		Living with a Smoker?	
Diverticulosis		Memory Loss		Other Substances Used:	
Heartburn (Frequent)		Multiple Sclerosis			
Hemorrhoids		Numbness & Tingling			
Hepatitis		Parkinson's Disease			
Hiatal Hernia		Seizures / Epilepsy		CANCER OF ANY KIND (List)	
Pancreatitis		Stroke/TIA or mini-stroke			
Reflux Disease / GERD		Tremors			
Stomach Problems / Ulcers		Other			
Other					

If you would like to receive our quarterly newsletter via email, please enter your email address: _____