Roadrunner Foot and Ankle
13660 N 94th Drive Suite A-3 **Date _____**
Peoria, Arizona 85381
Phone 623-933-4645 Fax 623-977-4482

Patient's Name:_____ Patient's Social Security #:_____

Patient's Address (local)_____ Birthdate_____/_____/_____ Age:_____

City, State and Zip_____ Sex: M F Marital Status: S M W D

Phone # (local)_____ Spouse Name_____

Cell Ph #_____Work #_____ Emergency Contact_____

Responsible Party_____ Emergency Contact Phone #_____

Responsible Party Phone # _____ Primary Care Physician_____

Your E-mail_____ Primary Care Physician#_____

*Preferred Language_____*Ethnic Group_____*Race_____
*These are government categories. If you need help please ask.

How did you hear about us? (circle one) Internet/Google, Physician Referral(Who)_____,Friend/Family,

Insurance, Other_____

EMPLOYMENT INFORMATION
Occupation/Prior Occupation if Retired._____

Patient/Parent Employer_____ Spouse's Employer_____

Employer Address_____ Employer Address_____

City, State and Zip_____ City, State and Zip_____

INSURANCE INFORMATION – We will copy your insurance card but we need you to fill out this section!

Primary Insurance_____ Secondary Insurance_____

Ins Co Phone #_____ Ins Co Phone #_____

Ins Co Address_____ Ins Co Address_____

Policy Holder Name/ Date of Birth_____ Policy Holder Name/Date of Birth_____

ID #_____ ID #_____

PHARMACY INFORMATION: Name:_____Cross Roads:_____

RX Plan Name:_____RX ID#_____
RX Plan Phone Number:_____

MEDICAL HISTORY

Name_____Date_____

Height_____Weight_____Shoe Size_____

What type of foot problems bring you to our office?_____

PAST MEDICAL HISTORY

Please check if you have any of the following:

Arthritis/Osteo Arthritis		**Liver Disease**	
Asthma		**Hep C Y or N**	
Cancer (What Kind)		**Lupus**	
COPD/Emphysema		**Psoriasis**	
Diabetes DX:	**A1C**	**Raynaud's**	
Gout		**Rheumatoid Arthritis**	
Heart Attack		**Seizures**	
High Blood Pressure		**Stomach Ulcer**	
High Cholesterol		**Stroke**	
HIV		**Thyroid Disease**	
Kidney Disease		**Peripheral Neuropathy**	
Dialysis Y or N		**Other:**	

Regular Medications (including over the counter) Dosage or Please Attach List:

Medication Name:	**Dosage**	**How many times per day?**

Previous Surgeries (Type and Date):

ALLERGIES

Please check if you have any of the following: Reaction can be rash, hives, throwing up, etc……

Medication Name	**Reaction**	**Medication Name**	**Reaction**
Penicillin		**Adhesive**	
Aspirin		**Latex**	
Codeine		**Shellfish**	
Sulfa		**Iodine**	
Novocain			

Other, please specify:_____

SOCIAL HISTORY

Do you smoke? Yes or NO Number of pack(s) per day?_____ Have you ever smoked? Yes or NO
Do you drink? Yes or NO How many ounces per week?_____
Do you exercise? Yes or NO

FAMILY HISTORY

Do you have family history of (please check all that apply)

	Father	Mother	Siblings	Grandparents
Diabetes				
Heart Disease				
Bleeding Disorders				
Stroke				
Gout				
Rheumatoid Arthritis				
High Blood Pressure				
Cancer Type				
Other:				

Please circle all that apply to YOU:

CONSTITUTIONAL Chills, Fatigue, Fever, Weight Gain, Weight Loss, Night Sweats
EYES Blurred Vision, Loss of Vision, Discharge
ENT Diminished Hearing, Tinnitus, Sore Throat
CARDIOVASCULAR Chest Pain, Palpitations, Calf Pain, Swelling Legs, Calf Pain with Walking, Shortness of Breath
RESPIRATORY Coughing, Frequent Wheezing, Difficulty Breathing
GASTROINTESTINAL Abdominal Pain, Constipation, Diarrhea, Nausea and Vomiting, Reflux, Bloody Stools
GENITOURINARY Urinary Incontinence, Blood in Urine, Pain on Urination, Discharge
MUSCULOSKELETAL Joint pain, Back Pain, Joint Stiffness, Muscle Pain, Joint Swelling
INTEGUMENTARY Extremely Dry Skin, Nail Deformities, Itching, Rash, Bumps/Nodules, Lesions
NEUROLOGIC Dizziness, Fainting, Headaches, Memory Loss, Seizures, Vertigo, Weakness, Pins/needles, Numbness, Loss of Balance, Falling
HEMATOLOGIC Easy bruising, Excessive Bleeding, Anemia
ENDOCRINE Hair Loss, Temperature Intolerances, Increased Skin Pigmentation, Increased Urination, Excessive Sweating
ALLERGY/ IMMUNOLOGIC Seasonal allergies, Frequent infections
PSYCHIATRIC Depression, Anxiety, Stress, Difficulty Sleeping

PATIENT SIGNATURE AND DATE_____

DPM Reviewed, sign and date_____

RELEASE OF INFORMATION/INSURANCE ASSIGNMENT
DO WE HAVE PERMISSION TO:

Leave a message on you answering machine at home? _____YES _____NO
Leave a message at your place of employment? _____YES _____NO
Discuss your medical condition with any member of your household? _____YES _____NO
If YES, with whom?_____

I authorize the release of any medical information necessary to process claims for services I have been provided. I permit a copy of this authorization to be used in place of the original. I authorize Roadrunner Foot and Ankle to apply for benefits on my behalf for any covered services. I request that payment from the insurance company be made directly to Roadrunner Foot and Ankle. I authorize Roadrunner Foot and Ankle to contact and forward any pertinent medical information to my other physician for their records. I further understand that I am responsible for all charges whether or not they are paid by my insurance company. I certify that the above information is correct.

Patient Signature:_____ Date:_____

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received Roadrunner Foot and Ankle Notice of Privacy Practices. (Copies are available at the front desk.)

_____ _____
Signature of patient or patient representative Date

FOR OFFICE USE ONLY
Documentation of Good Faith Efforts
To obtain patient's acknowledgement that they received provider's
Notice of Privacy Practices
(For use when acknowledgement cannot be obtained from patient)

The patient presented to the office and was provided with a copy of Covered Entity's notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- _____ Patient refused to sign
- _____ Patient was unable to sign or initial because:_____
- _____ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- _____ Other reason (describe): _____

_____ _____
Signature of Employee Completing Form Date

NO SHOWS AND LATE CANCELLATIONS POLICY

In an effort to serve our patients and the community well, we must utilize our time efficiently. When a patient makes an appointment, time is set aside for their needs, and work is performed to prepare their record for the visit. When a scheduled visit is not completed, there is a loss for another patient who could have used that available time, as well as wasted staff time. Therefore, we ask that when a scheduled visit cannot be met, it be cancelled at least twenty-four hours prior to the time of the appointment. For late cancellations or not showing for a scheduled appointment, a $50 fee will be charged.

I acknowledge receipt of this policy and agree to make payment for the amount of $50 in the event that I cancel an appointment without appropriate notice or neglect to show up for a scheduled appointment.

Signature of patient/responsible party:_____ Date:_____

FINANCIAL POLICY

Thank you for choosing Roadrunner Foot and Ankle as your health care provider. We strive to provide the most up to date and cost effective treatment, therapy and products for your foot and ankle care. Please understand that payment of your bill is considered a part of your treatment.

As a courtesy, Roadrunner Foot and Ankle, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Roadrunner Foot and Ankle that payment is due at the time of service. We require all patients to pay their deductible, copay and/or coinsurance payment at the time of service. Non Covered medical supplies or services must be paid in full at the time of service. Patients that do not have medical insurance will be required to pay for the services rendered in full on the date of service. We will try to accommodate patients by supplying an estimate prior to seeing the doctor. Payment plans are not accepted.

If you are covered by health insurance with podiatry benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all the financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. If we do not receive payment within 90 days, we will transfer the balance to your responsibility for payment**. There will be a $25.00 fee for all returned checks.**

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of you insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage for Roadrunner Foot and Ankle. Do not assume that you will not owe anything if you have more than one insurance policy.
I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient/Responsible Party Date

Signature of Witness Date