Patient Information Form

SUN VALLEY FOOT & ANKLE

Name: Date:
LAST FIRST M

Home Phone: ( ) Cell: ( )

Email Address:

Address:
STREET CITY STATE ZIP

Preferred Method of Contact: Letter Email

Sex: M F Age: Birth Date: Weight: Height:

In Case of Emergency Who Should Be Notified? Phone ( )

Additional Information

Primary Care Physician: Phone ( )
MEDICARE/HMO PATIENTS REQUIRED

Pharmacy Name: Phone ( )

Account Information

Person(s) Responsible for Account: Self Other

If Other, Please Provide Your Name:

Relationship to Patient: Date of Birth of the Responsible Party:

Address (If Different From Patient's):
STREET CITY STATE ZIP

Insurance Company:
PLEASE ENSURE RECEPTIONIST HAS MOST RECENT COPY OF YOUR INSURANCE CARD

ID Number: Group Number:

Patient Information Form (Continued)

SUN VALLEY FOOT & ANKLE

Additional Insurance

Is the Patient Covered by Additional Insurance? Y N If Yes, Subscriber's Name:

Relationship to Patient:

Address (If Different From Patient's):

STREET CITY STATE ZIP

Phone: ( ) Date of Birth:

PLEASE ENSURE RECEPTIONIST HAS MOST RECENT COPY OF YOUR INSURANCE CARD

Assignment and Release

I certify that I, and or my dependent(s) have insurance coverage and assign all benefits directly to the office of Sun Valley Foot & Ankle. I understand I will be responsible for any portion of the claim that is denied or not covered by my insurance company.

Signed: Date:

Release: I authorize the release to my insurance carriers any information necessary to process this claim.

Signed: Date:

New Patient Medical History Form

SUN VALLEY FOOT & ANKLE

Patient Name: _____ Date: _____
LAST FIRST M

Primary Care Doctor: _____ Referred By: _____

Please Explain Why You Are Here Today (Pain, Fracture, Injury, etc).

Past or Current Medical Conditions (Please Circle)

Addiction to Alcohol	Chronic Pain	Joint Replacement (Where:_____)
Addiction to Narcotics	Diabetes Type I	Kidney Disorder
AIDS / HIV	Diabetes Type II	Liver Disease
Anesthesia Problems	GI Problems (Ulcers, IBS, Reflux)	Respiratory Disease
Arthritis (Rheumatoid)	Heart Disease	Thyroid Problems
Arthritis (Osteo)	High Blood Pressure	Vascular Disease
Cancer	High Cholesterol	

Please List Any Other Medical Problems:

Surgical History

Please List All Surgical Procedures You Have Had:

Family History (Please Check All That Apply)

	Mother	Father	Grandparent
Anesthesia Problems	☐	☐	☐
Arthritis (Rheumatoid)	☐	☐	☐
Arthritis (Osteo)	☐	☐	☐
Cancer	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Vascular Disease	☐	☐	☐

New Patient Medical History Form (Continued)

SUN VALLEY FOOT & ANKLE

Please List All Current Medications: (Including Vitamins and Supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (Please Circle)

None
Antibiotics (Which Ones:_____)
Athletic Tape
Iodine
Latex
Local Anesthetics
Metals (Rash or Blistering with Jewelry)
Pain Medications (Which Ones: _____)
Please List Any Other Allergies:

Social History

Tobacco Use	Yes	No	How Often?
Alcohol Use	Yes	No	How Often?
Recreational Drugs	Yes	No	How Often?
Currently Pregnant?	Yes	No	Due Date:

Is There Anything Else Regarding Your Medical History That is Important For Your Doctor to Know?

How Did You Hear About Us? (Please Circle)

Dr's Office | Friend | Social Media | Google Search | Insurance | Advertisement

Other (please specify)_____

_____ _____ _____

Signature of Patient / Legal Guardian | Printed Name of Patient / Legal Guardian | Date

Patient Financial Responsibility

SUN VALLEY FOOT & ANKLE

Patient Name: _____

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO:

Sun Valley Foot and Ankle PLLC

I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and all charges which are not covered by my insurance. I understand that there will be a **$25.00** service charge on all returned checks. **I understand that verification of benefits is not a guarantee of payment.** (Insurance benefits are determined by your insurance company when the claim is received.) I understand that I will be responsible for any portion of the claim that is allowed by, but not covered by, my insurance company. Initial: _____. With the exception of Medicare, I understand that, upon request, I will be provided with all required documentation to collect reimbursement myself.

I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct.

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Release of Information:

I hereby authorize Sun Valley Foot and Ankle PLLC to release any medical information or incidental information to my referring physician or any other physicians who have been or may become involved in my care.

_____ _____ _____

Signature of Responsible Party | Printed Name of Responsible Party | Date

A Photostatic Copy of This Authorization Shall Be Considered as Effective and Valid as the Original