

Newswander Curtis Foot & Ankle
New Patient Medical History Form

Patient Name: _____ Today's Date: _____

Referred By: _____

Reason for your visit: _____ When did it start?: _____

Have you seen any other Doctor for this or any other foot or ankle problem?

Which Doctor? _____

Past or Current Medical Conditions:

- | | |
|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> GI Problems (ulcers, IBS, reflux) |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Arthritis (DJD, RA, Gout) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory Disease |
| | <input type="checkbox"/> Thyroid Problems |

Please list any other medical problems: _____

Family History:

- | | |
|--|--|
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | |

Please list current medications (can use back of sheet for additional space): _____

Allergies:

- | | |
|--|---|
| <input type="checkbox"/> Athletic Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Metals (rash or blistering with jewelry) |
| | <input type="checkbox"/> None |

Please list any other allergies to medications: _____

Surgery History (please list type of surgery had and date of occurrence: _____

Social History:

- | | | | |
|--------------------|-----------------------------|------------------------------|-----------|
| Tobacco use | <input type="checkbox"/> no | <input type="checkbox"/> yes | how much: |
| Alcohol use | <input type="checkbox"/> no | <input type="checkbox"/> yes | how much: |
| Recreational drugs | <input type="checkbox"/> no | <input type="checkbox"/> yes | how much: |
| Pregnant | <input type="checkbox"/> no | <input type="checkbox"/> yes | due date: |

Newswander Curtis Foot & Ankle Patient Financial Responsibility

Patient Name _____

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

Bradley L Newswander, DPM, PLC

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: _____ I understand that I am responsible for payment of my co-pay and co-insurance at the time service is rendered. 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.

Signature of Responsible Party

Printed Name of Responsible Party

Date

Release of Information:

I hereby authorize Bradley L Newswander, DPM, PLC 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.

Newswander Curtis Foot & Ankle

Summary of Notice of Privacy Practices

(HIPPA Privacy Policy)

This document summarizes how our office will protect your health information, your rights as a patient, and common practices in dealing with health information. The full Notice of Privacy Practices document is available upon request.

Uses and Disclosures of Health Information

We will use and disclose your health information in order to treat you or assist other health care providers in treating you.

We will use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us and other health care providers.

Uses and Disclosures Based on Your Authorization

We will not disclose your health information without written authorization, except in a few situations detailed in the Notice of Privacy Practices document.

Uses and Disclosures not Requiring Your Authorization

Some examples of situations where your health information may be released without your written authorization are:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purposes of public health and safety
- To government agencies for the purpose of their audits, investigations, and other oversight activities
- To government agencies for the purpose to prevent child abuse or domestic violence
- To FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders or search warrants and as otherwise required by Law

Patient Rights

As our patient, you have the right to the following:

- To have a copy of your health information
- To receive an accounting of certain disorders we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have any questions, concerns or complaints regarding our privacy practices, or if you would like a copy of the full Notice of Privacy Practices document, please contact our office at (480)840-3457.

By signing below, you are indicating that you have read and understand our Notice of Privacy Practices.

Signature

Date

Newswander Curtis Foot & Ankle

Patient Information Form

Date:	Home Phone ()	Cell ()		
Name:	(first)	(m.i.)	(last)	
Address:	(street)	(city)	(state)	(zip)
Sex:	M	F	Birth Date:	Marital Status:
	(pls circle)			
Primary care physician:	Phone #			
	(required for all Medicare, AHCCS, and HMO patients)			
Pharmacy name:	Phone #			

Primary Insurance Information

Insurance Company:	Phone #			
I.D. #:	Group #:			
Policyholder:	(first name)	(m.i.)	(last name)	
Policyholder date of birth:	Relationship to patient:			
Address if different from patient:	(street)	(city)	(state)	(zip)

Additional Insurance Information

Is patient covered by additional insurance?	Y	N	If yes, insurance company:	
I.D. #:	Group #:			
Policyholder:	(first name)	(m.i.)	(last name)	
Policyholder date of birth:	Relationship to patient:			
Address if different from patient:	(street)	(city)	(state)	(zip)

Assignment and Release

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

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

Newswander Curtis Foot & Ankle Injury Questionnaire

Patient Name _____ Date of Birth _____

Best number to contact you in case if questions (Cell phone is best) _____

If you are seeing the doctor for injuries sustained from an accident, you must fill out this form. The form must be filled out completely.

Please describe how the injury occurred _____

Date of injury _____

Where did the injury occur?

- | | |
|---|--|
| <input type="checkbox"/> At Home(patient's own residence) | <input type="checkbox"/> Work or place of employment |
| <input type="checkbox"/> Commercial business location | <input type="checkbox"/> Other public building _____ |
| <input type="checkbox"/> Other Location _____ | |

Was the injury related to your employment? Yes No

If Yes, this will be a worker's compensation claim. If you do not have your paperwork, including a claim number, please see the front desk. Please complete the following section.

Name of employer _____

Address _____

Phone () _____

If my injury resulted from my employment, and I choose to not submit charges to any third party, I will be financially responsible for charges incurred. I understand that medical insurance coverage will usually not cover services related to employment.

Signature of Responsible Party

Printed Name of Responsible Party

Date