Patient Demographics Form

Chart No:_____

FOOT & ANKLE INSTITUTE

We appreciate your help in updating our records and acquiring any new information per government regulations.

Regulation requires **ALL FIELDS below** be completed

Name:_____ Preferred Name: _____Birth Date:_____

Local Address: _____
Street City State Zip code

Mailing Address: _____
(If different than above) City State Zip code

Social Security Number: _____-_____-_____ **HOW DID YOU HEAR ABOUT Foot & Ankle Institute?** _____

Preferred Phone # (_____) _____ (H) (C) Alternate Phone # (_____) _____(H) (C)
Indicate home/cell **indicate home/cell**

Email Address: _____ Female _____ Male _____

Name of Parent: **(if under age 18)** _____Phone# _____

Emergency Contact: _____-_____ Phone #_____
Name **Relationship to Patient**

Name of the Legal Guardian _____ **(we must have a copy of the legal guardianship documents)**
Name of your Power of Attorney _____ medical _____ legal _____
(we must have a copy of the legal documents for your Power of Attorney)

Primary Care Physician: _____ Referring Physician: _____

Health Insurance coverage

Please provide a copy of your insurance card

Primary Insurance	
Subscribers Name:	Relationship:
Subscriber's Date of Birth:	

Secondary Insurance	
Subscribers Name:	Relationship:
Subscriber's Date of Birth:	

If a Workers Comp claim was filed, please provide adjustor's name: _____
Contact Phone# _____ **Claim number:** _____
Employer: _____ **Phone#:** _____
IN ORDER TO FILE WORKERS COMP CLAIMS, AUTHORIZATION FROM THE ADJUSTOR'S OFFICE IS REQUIRED.
If not, health insurance coverage must be provided or cash payment in full is required. (a referral is not an authorization)

Patient/Guardian Signature: _____ **Date:** _____

Employee: _____ **Date:** _____

Patient's Name: _____ Chart # _____

CREDIT AND FINANCIAL CHARGE AGREEMENT

By signing below, I hereby authorize any benefits due to be paid directly to Foot & Ankle Institute and/or South Main Surgery Center at 754 S. Main Street, Suite 3 St. George Utah 84770. I understand and agree that I am financially responsible for all deductible, co-insurance, co-pays, and non-covered service(s) or service(s) deemed as "non-medically necessary" by my benefit plan. I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred**. I authorize Foot & Ankle Institute and/or South Main Surgery Center to file a claim with my insurance carrier for services rendered. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.** All patients must complete our patient information form before seeing the doctor. You must provide valid and accurate insurance information in a timely manner, or you may be responsible for the balance of any claim(s) we file on your behalf. If payment is made it will be held and will become nonrefundable if the proper information is not provided within a reasonable time frame based on the member's insurance benefit carrier. If insurance information is not provided at time of service, or no active benefits through medical coverage are available, I agree to pay the self-pay rate at the time service(s) is provided. I agree that a late fee may be incurred on all past-due balances until paid in full. In the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to all other amount(s) that may be due, I will be responsible to pay a collection fee of up to 40% of the principal amount as provided by §12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection (whether incurred by Foot & Ankle Institute and/or South Main Surgery Center or its assigns) including by not limited to court costs, reasonable attorney fees, and interest (both pre-and post-judgment). Any interest due hereunder shall be calculated at a rate equal to 18% per annum and may, as determined by Foot & Ankle Institute and/or South Main Surgery Center or its assigns: (a) accrue on some or all amounts due and (b) compound as frequently as daily – meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period. I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone numbers) provided to Foot & Ankle Institute and/or South Main Surgery Center by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Foot & Ankle Institute and/or South Main Surgery Center or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails under the same terms at any e-mail address provided by me or anyone associated with me or acting on my behalf. In granting each and all the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.

BY SIGNING BELOW, I AGREE TO THE ABOVE STATEMENT AND ACKNOWLEDGE RESPONSIBILITY

Medical Information Release

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Foot & Ankle Institute and that Foot & Ankle may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or workers compensation carriers. I further acknowledge that Foot & Ankle Institute may disclose my patient information to referring or treating health care providers and for payment and health care operations. I hereby authorize Foot & Ankle Institute to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnosis test reports, films/images and other clinical information deemed necessary by Foot & Ankle Institute's physician's or representatives. I understand that I may inspect my protected heath information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Foot & Ankle Institute's privacy policy.

BY SIGNING BELOW, I AGREE WITH THE ABOVE STATEMENT AND ACKNOWLEDGE PRIVACY PRACTICES

Consent to Treat

I hereby consent to the medical treatment, diagnostic tests and other procedures, which Travis N. Tidwell, DPM and/or Ted Butterfield, DPM and/or Lary J. Smith, DPM and/or Carl C. Van Gils, DPM and/or Andrew B. Powell, DPM and/or Leon K. Reber, DPM and/or Brad S. Webb, DPM and/or Victor K. Myers, DPM and/or South Main Surgery Center may deem advisable in treatment of my podiatric care.

BY SIGNING BELOW, I ACKNOWLEDGE THE ABOVE STATEMENT CONSENTING TO BE TREATED BY FOOT & ANKLE PHYSICIANS

Patient signature_____ Date: _____

Parent's / Guardian: _____ Date: _____

Medicare Patient Agreement **(for Medicare and Medicare advantage patient's only)**

Medicare member's Name_____ Medicare Subscriber Number _____

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Foot & Ankle Institute and/or South Main Surgery Center for any services furnished to me by that provider. I authorize any holder of medical information and any information needed to determine these benefits or the benefits payable for related service about me to release this information to The Center for Medicare & Medicaid Services and its agents. This authorization is in effect until I choose to revoke this authorization in writing.

Medicare Member's signature:_____ Date: _____

Patient's Name: _____ Chart# _____

PATIENT HISTORY

What is your foot problem? _____ Duration of problem: _____

If this is due to an injury, give date of injury, description and location of injury: _____

_____

ALLERGIES: **Are you allergic to any of the following:**

Adhesive ☐Yes ☐No	**Morphine ☐Yes ☐No**	**Latex ☐Yes ☐No**	**Iodine ☐Yes ☐No**
Aspirin ☐Yes ☐No	**Sulfa Drugs ☐Yes ☐No**	**Codeine ☐Yes ☐No**	**Penicillin ☐Yes ☐No**

Other, please list (can use back of page) _____

Height: _____Ft_____In

Weight: _____Ibs/Kg

SOCIAL HISTORY:

Do you Smoke? ☐Never ☐ Former ☐ Everyday

Do you Chew Tobacco? ☐ Never ☐ Former ☐ Everyday

IMMUNIZATIONS:

If over age 65, have you had a pneumonia vaccine? ☐ Yes ☐ No If yes, Date:_____

REVIEW OF SYSTEMS/MEDICAL HISTORY:

Please circle/check the conditions for which you have been or are currently being treated for:

Cardiovascular: ☐ Rheumatic Fever ☐ Heart Attack ☐ Congestive Heart Failure ☐ Hypotension ☐ Hypertension ☐ Murmur ☐ Angina	**Endocrine:** ☐ Diabetes ☐ **Type 1** ☐ **Type 2** ☐ Managed by: ☐ **Diet** ☐ **Insulin** ☐ **Oral Medication** ☐ Last A1c Value: _____ ☐ Hypoglycemia ☐ Thyroid Dysfunctions	**Skin:** ☐ History of MRSA ☐ Lesions ☐ Moles ☐ Eczema ☐ Rashes	**Gastrointestinal:** ☐ Hepatitis ☐ Liver Dysfunction ☐ Ulcers ☐ Hiatal Hernia ☐ Reflux ☐ Diverticulitis	**Respiratory:** ☐ Asthma ☐ Pneumonia ☐ Short of Breath ☐ Emphysema
Musculo-Skeletal: ☐ Joint Pains ☐ History of Osteoarthritis ☐ Rheumatoid Arthritis	**Musculo-Skeletal:** ☐ Serious injuries or disorders of the Back ☐ Deformities ☐ Loss of Strength ☐ Fibromyalgia	**Hematologic:** ☐ Anemia ☐ Bleeding Tendencies	**Genitourinary:** ☐ Bladder Problems ☐ Prostate Problems ☐ ESRD, CRF, ARF ☐ Renal Insufficiency ☐ Receiving Dialysis	**Neurologic:** ☐ Weakness ☐ Numbness ☐ Strokes ☐ Seizures ☐ Migraines

Do you have any other condition or disease we should know about? _____

_____

CURRENT MEDICATIONS:

(Please complete as much of the following information as possible, use back of page if needed, OR *attach a list*)

Name	Name	Name

Diabetic Physician's Name: _____ Phone# _____

Preferred Pharmacy: _____ **Phone:** _____

Patient/Guardian Signature: _____ **Date:** _____

 Employee Signature:_____ Date: _____