NEW MEXICO Foot & Ankle INSTITUTE

Patient Information

Patient Name: _____ Date: _____

Social Security Number: _____-_____-_____ DOB: _____ Gender: M / F

Address _____

City_____ State _____ Zip _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Permission to email? Yes / No

Preferred Method of Communication *(please circle)* Home Phone Work Phone Cell Phone Email

Employment Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Disabled [ ] Student

Employer: _____ Occupation: _____

Race/Ethnicity: ☐ Asian ☐African American ☐Caucasian ☐Hispanic ☐Pacific Islander ☐Native American ☐Other ☐ Decline

Who do you authorize us to release to/discuss your medical information with?

Name: _____ Phone Number _____

Name: _____ Phone Number _____

Emergency Contact Name **(for emergencies only)**: _____

Contact Phone: _____ Relationship:_____

Billing & Insurance Information

Primary Insurance name: _____

Policy# _____ Group #: _____

Policy Holder Name: _____ DOB: _____Relationship: _____

Secondary Insurance name: _____

Policy# _____ Group #: _____

Policy Holder Name: _____ DOB: _____Relationship: _____

Referral Information *Who may we thank for referring you to our office?*

☐ FRIEND/FAMILY ☐ PCP/OTHER SPECIALIST ☐ WEBSITE/GOOGLE, ETC ☐OTHER_____

Name _____ Address _____

Primary Care Physician _____ Phone # _____

Pharmacy Name _____

Location_____ Phone # _____

NEW MEXICO Foot & Ankle INSTITUTE

Thank you for choosing us for your foot and ankle care. We are committed to providing you with quality and affordable health care. Please read the following policies and feel free to ask us any questions that you may have.

FINANCIAL POLICY I hereby assign all medical Insurance benefits to which I am entitled to NMFAI. I also authorize NMFAI to be my personal representative thereby allowing them to submit any and all appeals when my insurance company denies me benefits to which I am entitled. NMFAI may also request benefit information for prior authorizations and to initiate a formal complaint to any state or federal agency that has jurisdiction over my benefits.

It is your responsibility to understand the benefits offered by your insurance plan. Many plans have changed requiring a deductible or coinsurance to be applied when certain tests or procedures are performed in addition to co-pays for your office visits. Please be advised that a precertification or prior authorization from your health plan is not a guarantee of payment. Copayments are due at the time of service along with any outstanding balance from previous visits and you are responsible for giving us current insurance Information.

I understand that I will be billed for any balance due after my insurance pays. Unpaid balances over 90 days will be turned over to our collection agency and a fee for collection will be added to the account. The collection fee is $75 or 20% of collection balance, whichever is greater. Delinquent accounts will result in discharge from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

APPOINTMENT POLICY Please help us to serve you better by keeping your scheduled appointment. If you must change or cancel your appointment you need to do so at least one business day prior to your appointment time. This allows us time to try to schedule another patient in your appointment time.

You will be charged $25.00 for any of the following:

Failure to notify us of cancellation one business day prior to your scheduled appointment time
Not showing up for an appointment

These charges will be your responsibility and billed directly to you. Excessive no-shows, cancellations or rescheduling may result in discharge from our practice.

NOTICE OF PRIVACY POLICY Use and disclosure of your protected health information: Your protected health information will be used by NMFAI or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If NMFAI agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed-upon restriction will be a violation of the federal privacy standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. NMFAI reserves the right to modify the privacy practices outlined in the notice.

I have read and understand the policies stated above:

Patient/Responsible Party Signature _____ **Date** _____

NEW MEXICO Foot & Ankle INSTITUTE

Patient Name_____ DOB: _____

Name of Primary Care Physician _____

Physicians Address: _____

Physicians Phone _____ Date of last visit with PCP: _____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

PBM (Pharmacy Benefit Manager) CONSENT: Provides NMFAI information about which drugs are covered by the drug benefit plan and provides information about medications the patient is already taking by any provider to minimize adverse drug events.

I give consent to access my pharmacy records *(please circle)* **Agree / Decline**

Signature: _____ Date: _____

PODIATRIC HISTORY

What is the **main foot or ankle complaint** for which you came to be treated?

_____

_____

_____

When did it begin? _____

Have you received treatment(s) for this condition? YES / NO

Circle all treatments received for this condition:

Pain Medication	Antibiotics	X-Rays
Injection	Surgery	CT Scan
Hospitalization	Physical Therapy	MRI
Bone Scan	Ice/Stretching	

OTHER:

_____

Does this problem interfere with your activities? YES / NO

Explain:

_____

_____

_____

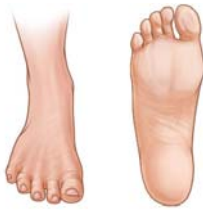
Have you ever experienced any of the following conditions?

Please ☑ check all that apply:

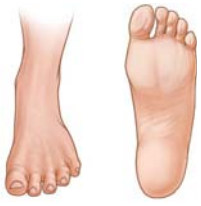
__ Ankle Instability	__ Hip Pain
__ Arthritis	__ Ingrown Toenails
__ Back Pain	__ Intoe-Out toe walking
__ Blisters	__ Knee Pain
__ Bone Spurs	__ Limb Length Discrep.
__ Bunions	__ Neuromas
__ Burning Feet	__ Numbness or Tingling
__ Corns / Calluses	__ Plantar Fasciitis
__ Flat Feet	__ Shin Splints
__ Foot Infections	__ Sprains
__ Fracture	__ Sweating / Odor
__ Fungal infections	__ Tendonitis
__ Gout	__ Tired Feet
__ Hammertoes	__ Ulcers
__ Heel Pain	__ Warts

Circle the degree of pain: Minimal 1 2 3 4 5 6 7 8 9 10 Severe

CIRCLE OR MARK THE PROBLEM AREAS



RIGHT



LEFT

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Patient Name_____ DOB: _____

YOUR PERSONAL MEDICAL HISTORY

Have you been treated for any of the following conditions? Please ☑ check all that apply: *More Info

__ Acid Reflux	__ Eye Problems *	__ Parkinson's Disease
__ Alcoholism	__ Fibromyalgia	__ Psychiatric Care *
__ Allergies	__ Headaches	__ Respiratory Disease *
__ Alzheimer's	__ Heart Condition *	__ Rheumatic Fever
__ Anemia	__ Hepatitis	__ Seizure Disorders/Epilepsy
__ Arthritis *	__ High Cholesterol	__ Sinus Problems *
__ Asthma *	__ HIV / AIDS	__ Sleep Apnea
__ Back Problems *	__ Hypertension/High Blood Pressure	__ Stomach Ulcers
__ Bleeding Disorders *	__ Low Blood Pressure	__ Stroke
__ Blood Clots / DVT / PE *	__ Hyperthyroidism	__ Tuberculosis (TB)
__ Cancer *	__ Hypothyroidism	__ Varicose veins
__ Circulatory Problems	__ Kidney/Bladder Problems *	__ Vertigo
__ Congestive Heart Failure (CHF)	__ Liver Disease *	OTHER: _____
__ Depression	__ Medical Implants *	**INFECTIONS:**
__ Diabetes *	__ Nerve System Disorder *	__ MRSA *
__ Drug or Chemical Dependency	__ Osteoporosis/Osteopenia	__ Hepatitis B *
__ Ear Problems *	__ Peripheral Arterial Disease	__ Hepatitis C *

SURGERIES /HOSPITALIZATIONS **Approx Date**

ALLERGIES: **YES / NO**

Please ☑ check all that apply

Adhesive Tape		Metal/Jewelry	
Anticoagulants		Novocaine	
Anti-inflammatory Meds		Peanuts	
Aspirin		Penicillin	
Codeine		Seafood	
Cortisone		Sulfa	
Iodine		Tylenol	
Latex		Motrin/Ibuprofen	

OTHER: _____

MEDICATIONS:

You can provide a list of your medications or list below

NAME OF MEDICATION	Strength/Mg	Take how often?

Do you participate in any exercise or physical activity on a regular basis? YES / NO If YES, what type and how often?

_____

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SOCIAL HISTORY

Please answer the following:

Occupation _____

Marital Status: Single Married Domestic Partner Divorced Widowed OTHER

History of STD's? YES / NO If yes, what type? _____

Use of Alcohol? YES / NO If yes, how much? _____

Use of Tobacco? YES / NO If yes, how much? _____

Use of Recreational Drugs? YES / NO If yes, type/frequency _____

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with any of the following?

- Arthritis
- Cancer (Type) _____
- Diabetes
- Heart Disease
- High Blood Pressure
- Stroke

REVIEW OF SYSTEMS

Please circle all conditions and symptoms that you **currently** have)

GENERAL:	FEVER	FATIGUE	SLEEPING PROBLEMS	WEIGHT LOSS/GAIN
SKIN:	RASH	ITCHING	LESIONS/SORES	DRY SKIN
HEAD:	INJURY	HEADACHE	CHANGES	VISION PROBLEMS
EYES:	BLURRY VISION	DOUBLE VISION	PAIN OR ITCHING	GLASSES/CONTACTS
ENT:	RINGING EARS	HEARING LOSS	SINUS CONGESTION	HOARSENESS
LUNGS:	COUGH	SNORING	WHEEZING	SHORTNESS OF BREATH
HEART:	CHEST PAIN	IRREG HEART BEAT	MURMUR	PALPITATIONS
DIGESTIVE:	NAUSEA	VOMITING	CONSTIPATION	DIARRHEA
URINARY:	FREQUENCY	INCONTINENCE	BURNING	BLEEDING
MUSKULOSKELETAL:		JOINT PAIN	WEAKNESS	DEFORMITY
VASCULAR:	CALF PAIN	LEG CRAMPS	SWELLING	VARICOSE VEINS
NEURO:	NUMBNESS	SEIZURES	DIZZINESS	WEAKNESS
PSYCHIATRIC:		ANXIETY	DEPRESSION	NERVOUSNESS
ENDOCRINE:	DIABETES	THYROID	HAIR LOSS	EXCESSIVE SWEATING
HEMATOLOGY:	ANEMIA	BRUISE EASILY	BLEEDING TENDENCY	COLD FEET/HANDS
OB/GYN:	PREGNANT	BIRTH CONTROL	HORMONE THERAPY	MENOPAUSAL

VITALS

Current Height _____Current Weight _____Shoe Size _____

I hereby give permission to NMFAI and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

_____

Patient or Authorized Signature: **Date:**