Patient Information

Today's Date: _____

Patient's Name: _____ Sex (circle one): Male / Female

Date of Birth: _____ Age: _____ Social Security #: _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Physical Address: _____
(Street) (City) (State) (Zip Code)

Home Phone:_____ Cell Phone:_____

Patient's Employer: _____ Work Phone: _____

Preferred Pharmacy: _____City_____ Email Address: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____ Did He / She refer you? Y / N

How did you hear about us? _____

Responsible Party Information (leave blank if self)

Responsible Party's Name: _____ Sex (circle one): Male / Female

Date of Birth: _____ Age: _____ Social Security #: _____

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone:_____ Cell Phone:_____

Responsible Party's Employer: _____ Work Phone: _____

Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Policy Holder: DOB:	Policy Holder: DOB:
ID #: Group #:	ID #: Group #:
Employer:	Employer:

Is this a work-related injury? Y or N. If Yes, Date of injury: _____ Carrier: _____

Claim #:_____Adjustor: _____ Phone #:_____

Podiatric and Health History

Chief Complaint (Circle and fill in the blank)

What is the nature of your pain? Sharp Dull Achy Throbbing Tingling Shooting

Where is your pain located? _____

How long ago did your pain start? _____

Did your pain come on suddenly or gradually? _____

Is your pain getting: Better Worse Staying the Same

What makes your pain better? _____

What makes your pain worse? _____

Review of Systems (Circle all that apply)

Constitutional:

Chills Fever Fatigue Weight Gain Fever Weight Loss

Cardiovascular:

Chest Pain Hair Loss on Legs Replacement Heart Valve Vascular Grafts Cramps in Legs/Feet Leg/Foot Ulcers
Extremities Cool High Blood Pressure Palpations Swelling of Legs Varicose Veins Extremities Discolored

Skin:

Athlete's Foot Fungal Nails Itching Mole Changes Dryness Hives Keloid Scar Rashes Eczema
Ingrown Nails Lumps Warts

Neurological:

Burning Neuromas Strokes Unsteady Gait Charcot Neuroarthropathy Numbness Tingling

Musculoskeletal:

Ankle Sprain Back Problems Bunions Corns Gout High Arch Feet Joint Pain Restricted Motion
Arch pain Broken Ankle Calluses Flat Feet Hammer/Mallet Toes In-toeing Joint Stiffness Muscle Cramps
Orthotic Use Shoe Insert Use Broken Foot Bone Childhood Foot Problems Gait (Walking) Problems
Heel Pain Joint Implants Knee Pain Muscle Stiffness Paralysis Toe Walking

Allergies: _____

_____

Medications:_____

_____

Family History: _____

_____

Surgical History: _____

_____

Medical History: (Circle all that apply)

Anemia	Anxiety	Arthritis	Asthma
BPH	Back Problems	Breast CA	CAD
CHF	COPD	Cancer	Cholesterol High
Dementia	Depression	Dermatitis	Diabetes
Epilepsy	GERD	Glaucoma	Gout
HIV	Headache	Hepatitis	Hypertension
MI	Migraine	Pneumonia	Renal Stone
Stroke	TB	Thyroid Ds	Ulcer (GI)

Social History: (Circle and fill in the blank)

Tobacco:

Current: Daily usage _____ pack/day, # of yrs _____

Former: Last used _____

Never smoked

Alcohol:

Beer	Social	Occasional	Light	Heavy
Wine	Social	Occasional	Light	Heavy
Hard Liquor	Social	Occasional	Light	Heavy

No Alcohol History

Shoe Size: _____ Men's/Women's Regular/Wide
Height: _____ ft _____in
Weight: _____lbs

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (Please Print) Parent or Authorized Representative (if applicable)

_____ _____

Signature Date

I authorize the release of medical information / test results to the following person(s) other than myself.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I authorize Squire Foot and Ankle PLLC to leave information / test results on my voice mail and / or answering machine at the contact numbers provided above.

_____ _____

Signature Date

PATIENT FINANCIAL RESPOSIBILITY

Assignment of Benefits and Financial Responsibility: I authorize the above listed medical practice and its' agent(s) to contact my insurance provider to verify my eligibility for insurance coverage. I authorize the release of information necessary to process this claim and hereby assign my insurance benefits be paid directly to Chad A. Squire DPM, FACFAS and Squire Foot and Ankle, PLLC. I acknowledge that I am responsible for paying all deductibles, co-payments, coinsurance amounts and any portion of non-covered services not paid by my insurance company or government benefit program. Such payments are due at time of service or immediately upon presentation of a bill. I understand that failure to fulfill my financial obligations may result in collection efforts if my account is considered significantly delinquent and all efforts to collect directly by the Squire Foot and Ankle, PLLC and its' agent(s) have been exhausted.

_____ _____

Signature Date

Notice of Privacy Practices

To Our Patients:

This notice describes how health information about you (as a patient of AACI Foot, Leg and Ankle care) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to your Privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to (Squire Foot and Ankle PLLC Chad A. Squire, Privacy officer, 932 S. Main St. Unit B203, Snowflake, AZ, 83937).

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to (Squire Foot and Ankle PLLC Chad A. Squire, Privacy officer, 932 S. Main St. Unit B203, Snowflake, AZ, 83937). You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint either directly with the practice, or to the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact (Squire Foot and Ankle PLLC Chad A. Squire, Privacy officer, 932 S. Main St. Unit B203, Snowflake, AZ, 83937). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If a disclosure of your protected health information was made for a reason other than treatment, payment or health care operations, you have a right to receive an accounting of the disclosures.

If you have any questions regarding this notice or our health information privacy policies, please contact Squire Foot and Ankle PLLC at (928) 457-0961 for further questions.