ARIZONA FOOT & ANKLE SURGERY

480.812.3636
FAX 480.812.3637

PATIENT INFORMATION

Last Name ________________________________ First Name _________________________Middle Initial___________

Address ____ City____________________________________

State ____________________________ Zip Code ___________________________________

Home # ________________________________ Work # _________________________________Ext.__________

Cell # _______________________________________ Other # ___________________________________

Birth date __________________________ SSN ____________________________ Sex (Male / Female) Age_______

Marital Status --- Single / Married / Divorce / Widow / Separated

Family Doctor ____________________________________ Referred By ______________________________________

PRIMARY COVERAGE

Relationship --- Myself / Spouse / Child / Other

Insured Person Name ____ SSN ____________________________

Date of Birth of Insured Person ____ Sex _______________

Name of Insurance Co. ____

Policy # ____ Group # ____

SECONDARY COVERAGE

Relationship --- Myself / Spouse / Child / Other

Insured Person Name ____ SSN ___________________________

Date of Birth of Insured Person ____ Sex ______________

Name of Insurance Co. ____

Policy # ____ Group # _______________________________________

MEDICAL HISTORY

General State of Health ☐ Good ☐ Fair ☐ Poor Height_________ Weight_________

Do you have any **allergies** to medications? (Y / N) If yes, please list __________________ ___________________

Current Medications (Y / N) If yes, please list ____________________________ __________________________

____________________ _______________________ _______________________ _______________________

Previous Surgeries & Dates ___________________ _____________________ Complications? (Y / N) _______

Have you ever had the following medical conditions: (circle)

Are you pregnant? (Y / N / Maybe)

Y / N Anemia	Y / N Anxiety/Depression	Y / N Arthritis/Type __________________
Y / N Asthma	Y / N Blood Disease	Y / N Cancer/Type____________________
Y / N Circulation Problems	Y / N Diabetes	Y / N Epilepsy/Seizures
Y / N Foot Numbness	Y / N Gout	Y / N Heart Conditions ________________
Y / N Hepatitis	Y / N High Blood Pressure	Y / N High Cholesterol
Y / N Liver Trouble	Y / N Menapause	Y / N Neurological Conditions __________
Y / N Phlebitis	Y / N Stomach Conditions	Y / N Stroke
Y / N Swelling Feet/Ankle (s)	Y / N Thyroid Condition	Y / N Tuberculosis
Y / N Varicose Veins		

Other Medical Conditions____

Which of these illnesses are in your immediate family? ____

Describe current problem (R) (L) (Both) ____

How long have you had the problem? __________________ Previous treatment ? ______________________________

Do you smoke tobacco? Y / N Did you smoke? Y / N How much? __________ How many years? ___________

Do you drink alcohol? Y / N Did you drink? Y / N How much? __________ How many years? ___________

Occupation?__________________________________Activities/Hobbies?____________________________________

I hereby give Dr. Chad L. Thompson permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information necessary to process my claim to my insurance company. I Furthermore authorize payment of medial benefits to my physician, directly, for services rendered. I understand that I am financially responsible for my bill. Cancellation notice must be provided at least 24 hours in advance or your account will be charged $30.00.

Signature ____ Date ________________________

I certify that I have received a copy of and understand Arizona Foot and Ankle Surgery's privacy policy and that I have had all of my questions answered by the staff.

Signature ____ Date _________________________