ARIZONA FOOT & ANKLE SURGERY

480.812.3636
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Info@azfootankle.com

PATIENT INFORMATION

First Name _____ Last Name _____Middle Initial_____

Mailing Address _____ City_____

State _____ Zip Code _____ E-Mail _____

Secondary Address _____

Home # _____ Cell # _____

Birth Date _____ Age_____ Sex (Male / Female)

Family Doctor _____ Referred By _____

Pharmacy_____ Crossroads_____

Emergency Contact Name_____ Phone# _____ Relationship_____

Arizona Foot and Ankle surgery will not share your information or send SPAM emails. We may use your email to contact you if we are unable to reach you by phone. AFAS will text an appointment reminder the business day before your appointment.

****PLEASE INSURE THAT PRIMARY AND SECONDARY INSURANCE INFORMATION IS UP TO DATE AND GIVEN TO THE FRONT OFFICE STAFF AT THE TIME OF CHECK IN.**

FINANCIAL AGREEMENT-PLEASE READ AND SIGN

I hereby give Dr. Chad L. Thompson permission to treat me or my dependents as necessary. I understand my insurance company may assist in paying the medical costs; however, I am ultimately responsible for all medical services rendered. I am responsible for understanding the policies and benefits of my medical insurance, including but not limited to authorizations, deductibles, coinsurance, and all out of pocket requirements. I understand that my co-pay is due on the date of service. I agree to pay all reasonable and customary collection and/or attorney's fees that may be incurred due to any delinquent accounts I may have. **I understand that I am responsible for knowing my appointment date/time and a $25 charge will be added to my account for any unexcused "no shows". The $25 fee will also apply for late arrivals (10+ min past my appointment time).** I authorize the release of any medical information necessary to my referring physician for continuing care and to my insurance company to assist in the processing of my claims. I Furthermore authorize payment of medial benefits to my physician, directly, for services rendered.

Signature _____ **Date** _____

I certify that I understand Arizona Foot and Ankle Surgery's privacy "HIPPA" policy (This is the laminated page given to you with your registration packet and can also be found on our website)

Signature _____ **Date** _____

MEDICAL HISTORY

General State of Health ☐ Good ☐ Fair ☐ Poor

Height_____ **Weight**_____ **Shoe Size**_____

Allergies/Sensitivities (**Y** / **N**) (i.e.- medications, metals, latex, tape, ETC…) **If yes**, **please list** _____

_____

Current Medications (**Y / N**) If yes, please list _____

_____

Previous Surgeries & Dates: _____

_____

Surgery Complications? (Y / N) _____

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

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** Gout	**Y / N** Epilepsy / Seizures
Y / N Foot Numbness	**Y / N** Diabetes **(I / II)**	**Y / N** Heart Conditions (explain) _____
Y / N Hepatitis	**Y / N** High Blood Pressure	**Y / N** Menopause
Y / N Liver Disease	**Y / N** High Cholesterol	**Y / N** Neurological Conditions _____
Y / N Phlebitis	**Y / N** Stomach Conditions	**Y / N** Stroke
Y / N Past Swelling Feet/Ankles	**Y / N** Tuberculosis	**Y / N** Varicose Veins
Y / N Thyroid Dz **(hypo/hyper)**	**Y / N** Are you **Currently** Pregnant?	

Other Medical Conditions_____

Which of the above illnesses are in your immediate family? _____

Do you smoke tobacco? **Y / N** If YES → How much? ____Pack(s)/day How many years? ___ If NO → year quit____

Do you drink alcohol? **Y / N** If YES → How much? _____ How many years? _____ If NO → year quit_____

Occupation?_____Activities/Hobbies?_____

Reason for visit today? (R) (L) (Both) Please explain:_____

_____

How long have you had the problem? _____

Previous treatment? _____

Print Name:_____ **Signature:**_____**Date:**_____

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MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Date of Birth: _____

I hereby authorize Arizona Foot and Ankle Surgery, to receive or release my medical records for continuation of care.

(AFAS may send records to the referring physician (if one is listed) but will never send medical records without the patients' knowledge. This release is kept in your chart for your convenience and can be changed at any time.)

Patient/Guardian Signature: _____

Date:_____

Arizona Foot and Ankle Surgery
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