Arizona Foot & Wound Specialists•James Longton, DPM, PC

Date: _____ Name: _____ Date of Birth: _____

Home Ph: (_____)_____ Cell Ph: (_____)_____ Work Ph: (_____)_____

Email: _____ Consent for Reminders Email/Voice: [ ] Yes

Preferred Method of Communication: [ ] Phone [ ] Email

Address: _____ Apt/Unit/Suite: _____ ZIP _____

SS#: _____ Age: _____ Sex: [ ] Female [ ] Male

[ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other

Occupation: _____ Employer: _____

Work Address: _____

Primary Insurance: _____ ID# _____

Name of Insured: _____ Date of Birth _____

Insured's Employer: _____ Relationship to Patient: _____

Secondary Insurance: _____ ID# _____

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

In case of an Emergency, contact: _____

Phone: (_____)_____ Relationship: _____

Whom may we thank for referring: _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Arizona Foot & Wound Specialists, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize this use of signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

MEDICARE AUTHORIZATION, if Applicable Please Sign

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Arizona Foot & Wound Specialists, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

1430 E Missouri Ave, Suite B150, Phoenix, Az 85014

Office: 602-445-6363 •www.azfootandwound.com• Fax: 602-602-429-8353

Arizona Foot & Wound Specialists•James Longton, DPM, PC

Date:_____ Name: _____

Reason for today's visit: _____

Height: _____ Weight: _____ Shoe Size: _____

What treatment methods have you tried? _____

Please indicate if **you** have or had any of the following:

[ ] AIDS/HIV
[ ] Alcohol Abuse
[ ] Allergies to Medicines/Drugs
[ ] Anticoagulant Therapy
[ ] Arthritis
[ ] Artificial Heart Valves or Joints
[ ] Asthma or Respiratory Disease
[ ] Back Problems
[ ] Bleeding Disorders
[ ] Cancer
[ ] Chemical Dependency
[ ] Chest Pain or Angina
[ ] Circulatory Problems
[ ] Diabetes
[ ] Diabetic Foot Wound
[ ] Gout
[ ] High Blood Pressure
[ ] Heart Disease
[ ] High Cholesterol
[ ] Neuropathy
[ ] Kidney Problems
[ ] Liver Disease or Hepatitis
[ ] Phlebitis
[ ] Rheumatic Fever
[ ] Shortness of Breath
[ ] Vascular Disease
[ ] Stroke or Heart Attack
[ ] Thyroid Disease
[ ] Ulcer or Gastritis
[ ] Other:_____

Family History: Please specify family member next to condition:

Mother/ Father/ Sibling

[ ] Heart Disease
[ ] Diabetes
[ ] Cancer
[ ] Arthritis
[ ] Vascular Disease
[ ] Neuropathy
[ ] Bleeding Disorder
[ ] Liver Disease
[ ] Circulatory Problems

History of tobacco use: [ ] Yes [ ] No [ ] Quit Years Smoked: _____

Surgeries: _____

Hospitalizations: _____

Family Physician: _____ Ph: (_____)_____ Last Visit Date:_____

Are you now, or have you been under any other doctor's care for any reason over the past two years? [ ] Yes [ ] No
If Yes, please explain: _____

Curent Medications/Dosage:_____

_____

Allergies:

[ ] Pain Meds
[ ] Adhesive Tape
[ ] Penicillin
[ ] Aspirin
[ ] Codeine
[ ] Seafood
[ ] Iodine
[ ] Demerol
[ ] Sulfa
[ ] Local Anesthetics
[ ] Novacaine
[ ] Other: _____

Pharmacy Name/Main Cross Streets: _____ Pharmacy Phone: _____
Consent to Retrieve Medication History from Pharmacy: [ ] Yes [ ] No

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my feet and/ or ankle.

_____ _____
Patient Signature Date

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PATIENT FINANCIAL OBLIGATION AGREEMENT

I,_____, UNDERSTAND THAT I AM OBLIGATED FOR THE FOLLOWING:

_____ CO-PAYS AND DEDUCTIBLES AT THE TIME OF MY APPOINTMENT(S).
(INITIAL)

_____ $45.00 CHARGE FOR ANY MISSED APPOINTMENT(S) AND/ OR APPOINTMENTS WHICH
(INITIAL) ARE NOT CANCELLED 24 HOURS PRIOR TO MY SCHEDULED APPOINTMENT TIME.

_____ $20.00 RETURNED CHECK FEE
(INITIAL)

_____ $20.00 LATE FEE IF MY PATIENT BALANCE IS 60 DAYS PAST DUE.
(INITIAL)

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____
DATE

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Email: _____ Consent for Reminders Email/Voice: [ ] Yes

Preferred Method of Communication: [ ] Phone [ ] Email

Address: _____ Apt/Unit/Suite: _____ ZIP _____

SS#: _____ Age: _____ Sex: [ ] Female [ ] Male

[ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other

Occupation: _____ Employer: _____

Work Address: _____

Primary Insurance: _____ ID# _____

Name of Insured: _____ Date of Birth _____

Insured's Employer: _____ Relationship to Patient: _____

Secondary Insurance: _____ ID# _____

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

In case of an Emergency, contact: _____

Phone: (_____)_____ Relationship: _____

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_____ _____ _____

Responsible Party Signature Relationship Date

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[ ] Heart Disease
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[ ] Kidney Problems
[ ] Liver Disease or Hepatitis
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[ ] Cancer	[ ] Neuropathy	[ ] Circulatory Problems

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Curent Medications/Dosage:_____

_____

Allergies:

[ ] Pain Meds	[ ] Aspirin	[ ] Iodine	[ ] Local Anesthetics
[ ] Adhesive Tape	[ ] Codeine	[ ] Demerol	[ ] Novacaine
[ ] Penicillin	[ ] Seafood	[ ] Sulfa	[ ] Other: _____

Pharmacy Name/Main Cross Streets: _____ Pharmacy Phone: _____
Consent to Retrieve Medication History from Pharmacy: [ ] Yes [ ] No

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