Roadrunner Foot and Ankle
13660 N 94th Drive Suite A-3
Peoria, Arizona 85381
Phone 623-933-4645 Fax
623-977-4482

www.roadrunnerfootandankle.com

Date ______________________

Patient's Name:____ Patient's Social Security #:___________________________________

Patient's Address (local)_______________________________ Birthdate__________/_________/_________ Age: _____________

City, State and Zip______________________________________ Sex: M F Marital Status: S M W D

Phone # (local)____ Spouse Name____

Cell Ph #____________________Work #___________________ Emergency Contact____

Your Email ____ Emergency Contact Phone #________________________________

Responsible Party ______________________________________ Relationship to Patient: _____________________________

Responsible Party Phone #_______________________________ Primary Care Physician___________________________________

Primary Care Physician#__________________________________

*Preferred Language____________________*Ethnic Group_________________________*Race____________________________

*These are government categories. If you need help please ask.

How did you hear about us? (check and fill out) Ad Direct Mail Email Friend (Name) __________________, Internet/Google
Patients That Refer a Friend (Name) _____________________________ PCP(Name) ____
Referring Provider (Name) _________________________________ Walk In Other _______________________________

EMPLOYMENT INFORMATION

Occupation/Prior Occupation if Retired.____

Patient/Parent Employer________________________________ Spouse's Employer_______________________________________

Employer Address______________________________________ Employer Address____

City, State and Zip_____________________________________ City, State and Zip_______________________________________

INSURANCE INFORMATION

Primary Insurance______________________________________ Secondary Insurance_____________________________________

Ins Co Phone #____ Ins Co Phone #____

Ins Co Address____ Ins Co Address____

Policy Holder Name/ Date of Birth___________________________ Policy Holder Name/Date of Birth______________________________

ID #____ ID #____

PHARMACY INFORMATION: _________________________________ CROSS ROADS: _____________________________________

RX Plan Name: ____ RX ID#: ____

RX Plan Phone Number: _____________________________________

MEDICAL HISTORY

Name____Date____________________________________

Height________________________Weight_________________________Shoe Size__________________________

What type of foot problems bring you to our office?____

PAST MEDICAL HISTORY

Please check if you have any of the following:

Arthritis/Osteo Arthritis		**Liver Disease**	
Asthma		**Hep C**	**Yes No**
Cancer (What Kind)		**Lupus**	
COPD/Emphysema		**Psoriasis**	
Diabetes DX:	**A1C Number**	**Raynaud's**	
Gout		**Rheumatoid Arthritis**	
Heart Attack		**Seizures**	
High Blood Pressure		**Stomach Ulcer**	
High Cholesterol		**Stroke**	
HIV		**Thyroid Disease**	
Kidney Disease		**Peripheral Neuropathy**	
Dialysis	**Yes No**	**Other: Please list**	

Regular Medications (including over the counter) Dosage or Please Attach List:

Medication Name:	**Dosage**	**How many times per day?**

Previous Surgeries (Type and Date):

ALLERGIES

Please check and list if you have any of the following: Reaction can be rash, hives, throwing up, etc………

Medication Name	**Reaction**	**Medication Name**	**Reaction**
Penicillin		**Adhesive**	
Aspirin		**Latex**	
Codeine		**Shellfish**	
Sulfa		**Iodine**	
Novocain			

Other, please specify:____

SOCIAL HISTORY

Do you smoke? Yes No   Number of pack(s) per day? ____________   Have you ever smoked? Yes No

Do you drink? Yes No   How many ounces per week? ____________

Do you exercise? Yes No

FAMILY HISTORY

Do you have family history of (please check all that apply)

	Father	Mother	Siblings	Grandparents
Diabetes				
Heart Disease				
Bleeding Disorders				
Stroke				
Gout				
Rheumatoid Arthritis				
High Blood Pressure				
Cancer Type				
Other - Please List :				

Please check all that apply to YOU:

CONSTITUTIONAL Chills Fatigue Fever Night Sweats Weight Gain Weight Loss

EYES Blurred Vision Discharge Loss of Vision

ENT Diminished Hearing Sore Throat Tinnitus

RESPIRATORY Coughing Difficulty Breathing Frequent Wheezing

CARDIOVASCULAR Calf Pain Calf Pain with Walking Chest Pain Palpitations Shortness of Breath Swelling Legs

GASTROINTESTINAL Abdominal Pain Bloody Stools Constipation Diarrhea Nausea and Vomiting Reflux

MUSCULOSKELETAL Back Pain Joint pain Joint Stiffness Joint Swelling Muscle Pain

PSYCHIATRIC Anxiety Depression Stress

INTEGUMENTARY (SKIN) Bumps/Nodules Extremely Dry Skin Itchy Skin Lesions Nail Deformities Rash

NEUROLOGIC Dizziness Fainting Falling Headaches Loss of Balance Memory Loss Numbness Pins/Needles Seizures Vertigo Weakness

ENDOCRINE Excessive Sweating Hair Loss Increased Skin Pigmentation Increased Urination Temperature Intolerances

HEMATOLOGIC Anemia Easy bruising Excessive Bleeding

ALLERGY/ IMMUNOLOGIC Frequent infections Seasonal allergies

GENITOURINARY Blood in Urine Discharge Pain on Urination Urinary Incontinence

DPM Reviewed, sign and date ______________________________

PATIENT SIGNATURE OR PATIENT REPRESENTATIVE ______________________________

DATE: ____________________

RELEASE OF INFORMATION/INSURANCE ASSIGNMENT
DO WE HAVE PERMISSION TO:

Leave a message on you answering machine at home? ______YES ______NO
Leave a message at your place of employment? ______YES ______NO
Discuss your medical condition with any member of your household? ______YES ______NO
If YES, with whom?____

I authorize the release of any medical information necessary to process claims for services I have been provided. I permit a copy of this authorization to be used in place of the original. I authorize Roadrunner Foot and Ankle to apply for benefits on my behalf for any covered services. I request that payment from the insurance company be made directly to Roadrunner Foot and Ankle. I authorize Roadrunner Foot and Ankle to contact and forward any pertinent medical information to my other physician for their records. I further understand that I am responsible for all charges whether or not they are paid by my insurance company. I certify that the above information is correct.

Patient Signature or Patient Representative: ____

Date:____

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received Roadrunner Foot and Ankle Notice of Privacy Practices. (Copies are available at the front desk.)

____ ________________________
Signature of patient or patient representative Date

FOR OFFICE USE ONLY
Documentation of Good Faith Efforts
To obtain patient's acknowledgement that they received provider's
Notice of Privacy Practices
(For use when acknowledgement cannot be obtained from patient)

The patient presented to the office and was provided with a copy of Covered Entity's notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ____ Patient refused to sign
- ____ Patient was unable to sign or initial because: ______________________________
- ____ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity
- ____ Other reason (describe): ____

____ ________________________
Signature of Employee Completing Form Date

NO SHOWS AND LATE CANCELLATIONS POLICY

In an effort to serve our patients and the community well, we must utilize our time efficiently. When a patient makes an appointment, time is set aside for their needs, and work is performed to prepare their record for the visit. When a scheduled visit is not completed, there is a loss for another patient who could have used that available time, as well as wasted staff time. Therefore, we ask that when a scheduled visit cannot be met, it be cancelled at least twenty-four hours prior to the time of the appointment. For late cancellations or not showing for a scheduled appointment, a $50 fee will be charged.

I acknowledge receipt of this policy and agree to make payment for the amount of $50 in the event that I cancel an appointment without appropriate notice or neglect to show up for a scheduled appointment.

Signature of patient/responsible party:____Date:________________

FINANCIAL POLICY

Thank you for choosing Roadrunner Foot and Ankle as your health care provider. We strive to provide the most up to date and cost effective treatment, therapy and products for your foot and ankle care. Please understand that payment of your bill is considered a part of your treatment.

As a courtesy, Roadrunner Foot and Ankle, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Roadrunner Foot and Ankle that payment is due at the time of service. We require all patients to pay their deductible, copay and/or coinsurance payment at the time of service. Non Covered medical supplies or services must be paid in full at the time of service. Patients that do not have medical insurance will be required to pay for the services rendered in full on the date of service. We will try to accommodate patients by supplying an estimate prior to seeing the doctor. Payment plans are not accepted.

If you are covered by health insurance with podiatry benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy.
Accepting your insurance does not place all the financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. If we do not receive payment within 90 days, we will transfer the balance to your responsibility for payment**. There will be a $25.00 fee for all returned checks.**

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of you insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage for Roadrunner Foot and Ankle. Do not assume that you will not owe anything if you have more than one insurance policy.
I have read the Financial Policy. I understand and agree to this Financial Policy.

____
Signature of Patient/Responsible Party Date

____
Signature of Witness Date