Heelex SURPRISE

12329 W BOLA DR, SUITE 100 SURPRISE, AZ 85378
(PH) (623)270-7441 (FAX) (623)270-7442

PATIENT INFORMATION

Patients Name: _____Middle Initial: _____ Gender: Male/Female

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

Address: _____ Apt #: ____ City:_____ State: _____ Zip: _____

Preferred method of contact: Home phone, Cell Phone or Email **Okay to leave message**? Yes/No

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Emergency Contact Name: _____ Phone: _____

Relationship to patient: _____

Responsible Party Name: _____ DOB: _____ Phone:_____

Address (If Different): _____ City: _____

Marital Status: **S M W D** **Student Status**: Full-time/Part-time **Employment Status**: Full-time/Part-time

Patients Employer: _____ Occupation:_____

How did you hear about us? Friend/Family Facebook Website Doctor Other:_____

Primary Language: English ☐ Spanish ☐ Chinese ☐ Other ☐ _____

Race: American Indian ☐ Asian ☐ Black/African American ☐

Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐

Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Social Security #: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance:_____

Policy Number: _____ Group Number:_____

Policy Holder Name: _____ DOB: _____ Social Security #: _____

Policy Holder Address: _____ City: _____ State: _____ Zip: _____

ASSIGNMENT OF BENEFITS: I authorize the release of information necessary to process this claim and hereby assign my insurance benefits to be paid directly to Heelex,LLC. I acknowledge financial responsibility for services which are not covered by my insurance company. CONSENT FOR MEDICAL TREAMENT: I authorize Heeelex,LLC to provide medical care including, but not limited to, diagnostic examinations, radiology, laboratory testing and necessary medical treatment.

SIGNATURE: _____ **DATE**: _____

Last Name: _____

HISTORY

What is the reason for your visit today?

_____

Have you ever seen a doctor or podiatrist: Yes / No **If yes** please list the name of physician.

Name:_____ Last visit: _____

Have you ever had radiation therapy? Yes / No Are you currently taking Methotrxate? Yes / No

What time of the day is the pain felt the most? AM/ PM

Please indicate the athletic activities in which you participate:

Walking____X week Jogging/Running___X week Swimming____X week Biking___X week

Other: _____

ALLERGIES **No Known Allergies**: _____ Latex ____ Tape ____ Aspirin ____

Local Anesthetic ___ Epinephrine ____ Iodine ____ Codeine____

Cortisone ____ Sulfa ____ Eggs ____ Penicillin:_____ Other: _____

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

Do you drink Alcohol? Yes/No If yes, check how often: _____

Do you now or have you ever smoked tobacco? Yes/No If yes, check how often:

None currently & abstinence >10years_____ Abstinence 1-10 years _____

PHARMACY: _____ Cross Streets: _____ Phone Number: _____

Current Medications

Drug Name Dose Prescribing MD

_____

_____

_____

_____

_____

_____

Past Surgeries/Hospitalizations

(Please indicate year)

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Anxiety	Yes	No	Fibromyalgia	Yes	No	Lung Disease	Yes	No
Asthma	Yes	No	Gout	Yes	No	Specify:		
Bipolar	Yes	No	Head Trauma	Yes	No	Migraines	Yes	No
Bleeding Problem:	Yes	No	Heart Disease	Yes	No	Neurological Problem:	Yes	No
Specify:			Hepatitis A,B, C	Yes	No	Osteoarthritis	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Rheumatoid Arthritis	Yes	No
Specify:			High Cholesterol	Yes	No	Stroke/CVA/TIA	Yes	No
Depression	Yes	No	HIV	Yes	No	Thyroid Disease	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Ulcers	Yes	No
Specify: Diet/Pills/Insulin			Liver Disease	Yes	No	Specify:		
DVT/Blood Clots	Yes	No	Specify:			Other:		

Do **you** have any history of **Skin Cancer**? Yes / No **Vascular Disease**? Yes / No

Do **you** have any autoimmune disease(s)? Yes / No If **Yes**, please list _____

FAMILY HISTORY

Is there any history of **Cardiac Disease**? Yes / No

If yes, list relationship _____

Are you currently seeing a **Cardiologist**? **If yes** Name _____

Phone#_____

Is there any history of **Diabetes**? Yes / No

If yes, list relationship _____

Is there is any family history of **Vascular Disease**? Yes / No

If yes, list relationship _____

PATIENT FINANCIAL RESPONSIBILTY AGREEMENT AND ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

I understand I am required to pay all co-pays prior to being seen by the doctor unless arrangements have been made.

If my insurance requires referrals for the office visits, I take full responsibility to obtain them prior to my appointment. If this is not done, I agree to pay all claims denied because of lack of proper referral or I may choose not to be seen until a referral is received.

I understand that some items and/or procedures authorized by my insurance do not guarantee payment and may later be denied. I accept financial responsibility for these items and/or procedures if they are denied even if prior authorization is obtained. I also understand that these items cannot be returned.

I understand that some exams and/or procedures require services from an outside lab. I accept that these services may be billed independently by the facility to my insurance.

I understand that a $30.00 returned check fee will be charged for all returned checks.

I understand that a $25.00 fee may be charged for disability paperwork.

We require at least a 24 hour cancellation notice if for any reason you cannot make your appointment. I understand that a $25.00 fee may be charged for all missed appointments.

I understand that if I change my insurance, I am responsible to notify the office.

I understand I must give ALL insurance information at the time of my Initial Appointment.

I understand that there may be a charge for printing medical records.

I agree that my account will be "paid in full" upon receiving the statement. Any courtesy fees are only applicable upon full-payment of fees at the time of visit. If my account is not paid-in-full upon presentation of the statement, I agree to pay a monthly re-billing fee of $3.00 per month until paid.

I agree that in the event my account is turned over to an attorney or collections agency, I agree to pay any and all actual collection fees charged and or attorney's fees, fees incurred in an amount not to exceed 50% of the balance due. I further agree that the jurisdiction for any action filed for the purpose of collection and any sums due on this account shall be the place where the contract was made, specifically Maricopa County, Arizona. A photocopy for facsimile of this agreement shall be considered as valid as the original.

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) and understood the notice.

Signature _____ Date _____

Printed Name of responsible party _____

Relationship to patient _____