12329 W BOLA DR, SURPRISE, AZ 85378
(623)270-7442 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 ____