PATIENT INFORMATION

Please complete all the fields below.

PATIENT INFO

First Name ______________________

Last Name ______________________ MI ______

Date of Birth ______/______/______

Address ______________________

City ______________ State ______ Zip ______

Social Security Number ______-______-______

Sex: ☐ Female ☐ Male

Marital Status (Circle): S M D W

Home Phone ______________________

Work Phone ______________________

Cell Phone ______________________

Nearest Living Relative ______________________
(NOT LIVING WITH YOU)

Nearest Living Phone ______________________

Primary Care Physician ______________________

Referred by ______________________
(HOW DID YOU HEAR ABOUT US?)

Patient's Employer Name ______________________

Employer Name Phone ______________________ Ext. ______

Primary Care Physician ______________________

Accident Info Date (if applicable) ______/______/______

☐ Work Related ☐ Auto ☐ Other ______________

SIGNATURES

CONTRACT FOR PAYMENT, ASSIGNMENT OF BENEFITS, ADVANCED BENEFICIARY NOTICE (ABN), RELEASE OF INFORMATION & ACKNOWLEDGMENT OF HIPPA RIGHTS
(As found on the next page)

____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE REQUIRED

Date ______/______/______

____

(IF PATIENT IS A MINOR, SIGNATURE OF PARENT/LEGAL GUARDIAN IS REQUIRED)

Date ______/______/______

RESPONSIBLE PARTY INFO

First Name ______________________

Last Name ______________________ MI ______

RELATIONSHIP TO PATIENT:

☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Date of Birth ______/______/______

Address ______________________

City ______________ State ______ Zip ______

Social Security Number ______-______-______

Home Phone ______________________

Spouse Name ______________________

Spouse Date of Birth ______/______/______

Spouse SS Number ______-______-______

Res. Party's Employer ______________________

Employer Phone ______________________

Spouse Employer ______________________

Spouse Employer Phone ______________________

INSURANCE INFORMATION

Primary Insurance Company ______________________

Phone ______________________

Subscriber's Name ______________________

Address ______________________

City ______________ State ______ Zip ______

Contract (ID) Number ______________________

Group Name ______________________

Group # ______________ Copay Amount $ ______

Secondary Insurance Company ______________________

Phone ______________________

Subscriber's Name ______________________

Address ______________________

City ______________ State ______ Zip ______

Contract (ID) Number ______________________

RELATIONSHIP TO PATIENT:

☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insured's Date of Birth ______/______/______

Group Name ______________________

Group # ______________ Copay Amount $ ______

DANIEL HUFF, DPM • ANDREW BURGON, DPM

272 N. SPRINGCREEK PKWY · PROVIDENCE, UT 84332 · OFFICE (435) 787-1023 · FAX (435)787-1883

CONTRACT FOR PAYMENT, ASSIGNMENT OF BENEFITS, ADVANCED BENEFICIARY NOTICE (ABN), RELEASE OF INFORMATION & ACKNOWLEDGMENT OF HIPPA RIGHTS

ATTENTION MEDICARE/ MEDICAID PATIENTS: The following statement is also an Advanced Beneficiary Notice (ABN):

I, the undersigned, understand and agree that I am financially responsible for ALL fees incurred for services rendered by the Foot & Ankle Center of Providence and/or Daniel J. Huff, DPM. I agree that I am financially responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by my insurance carrier(s) or third party payer. A $20.00 billing fee will be charged monthly for Insurance “Co-Pays” that are not collected at the time of service. A 1.5% monthly Interest Fee (18% Annually) will be charged on any balance more than 90 days outstanding. Further I, agree to pay a $25.00 fee for any missed (no show) appointments should I fail to notify the Foot & Ankle Center of Providence/ Daniel J. Huff, DPM within 24 hours prior to the appointment date. Should my account be turned over to a collection agency, a Collection Fee of 40% of the existing balance will be applied toward my account. I agree to pay ALL collection costs which may include court costs, attorney’s fees and all incidental fees that incur as a result of my account being turned over to a collection agency. I authorize the signature below to be used as a valid signature for all Credit Card/ Debit Card transactions taken over the phone. Should a refund be issued back onto my card, a Transaction Fee of 8% of the original amount charged toward the card plus any amount of an outstanding balance on my existing account will be withheld from the refund transaction(s) and applied toward said outstanding balance.

I, the undersigned, authorize the payment of all Insurance Benefits due me to be paid directly to the Foot & Ankle Center of Providence and/or Daniel J. Huff, DPM for service rendered to the above mentioned patient.

I, the undersigned, authorize the release of any medical and/or other pertinent information for the purpose of processing Insurance Claims & Pre-Authorization requests. I further, authorize the release of the records of all previous, present and future prescriptions of a controlled substance from the State Board Pharmacy Office of the state were in I reside and from ALL surrounding border states to be given to the Foot & Ankle Center of Providence and/or Daniel J. Huff, DPM so long as I am a current patient.

I, the undersigned, acknowledge that I have been given the opportunity to read the “Privacy Practices”. I understand that the Foot & Ankle Center of Providence will take every precaution to safeguard my “Protected Health Information” (PHI). By signing this acknowledgment, I am Consenting to the Foot & Ankle Center of Providence use and disclosure of my PHI to carry out treatments, payment, and health care operations. If I do not sign this consent, or later revoke it, the Foot & Ankle Center of Providence/ Daniel J. Huff, DPM may decline to provide treatment to myself, or the Patient, if acting as the legally authorized representative of the Patient.

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PATIENT HISTORY

Please complete all the fields below.

Name ______________________ Age _______

ALLERGIES (check all that apply)

- ☐ Adhesive Tape
- ☐ Morphine
- ☐ Sulfa Drugs
- ☐ Asprin
- ☐ Penicillin
- ☐ Latex
- ☐ Chemicals
- ☐ Foods
- ☐ Codeine
- ☐ Antibiotics ______________________
- ☐ Other______________________

HAS ANYONE IN YOUR FAMILY (MOTHER, FATHER, SIBLINGS, GRANDPARENTS, AUNT, UNCLE, ETC.) HAD ANY OF THE FOLLOWING? IF SO, WHEN?

Arthritis______________________

Birth Defects ______________________

Cancer (what kind?) ______________________

____

Diabetes ______________________

Heart Attack ______________________

High Blood Pressure ______________________

Osteoporosis ______________________

Stroke ______________________

Do you drink alcohol? ☐ Yes ☐ No

Do you Smoke ☐ Yes ☐ No

If yes, # of packs per day _______ # of Years_______

Do you chew tobacco? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If female, are you pregnant? ☐ Yes ☐ No

PLEASE LIST ALL SURGERIES YOU HAVE HAD, ALONG WITH THE APPROXIMATE DATES:

____

____

____

____

____

____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:

____

____

____

Reviewed by ______________________

Date ______ /______ /______________

Please check those YOU have been treated for:

HEART
- ☐ Rheumatic Fever
- ☐ Murmur
- ☐ Chest Pain
- ☐ Angina,
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Hypotension
- ☐ Hypertension
- ☐ Heart Disease

MUSCULO-SKELATAL
- ☐ Serioud Injuies
- ☐ Back Problems
- ☐ Deformities
- ☐ Loss of Strength
- ☐ Joint Pain
- ☐ Osteoarthritis
- ☐ Rheumatiod Arthritis
- ☐ Lupus Cramps

LIVER
- ☐ Hepatitis
- ☐ Liver Dysfunction

SKIN
- ☐ Lesions
- ☐ Moles
- ☐ Eczema
- ☐ Rashes
- ☐ Cancer

BLOOD
- ☐ Anemia
- ☐ Bleeding Tendencies
- ☐ Blood Clots

KIDNEYS
- ☐ Kidney
- ☐ Bladder
- ☐ Prostate Problems

NEUROLOGIC
- ☐ Depression
- ☐ Weakness
- ☐ Numbness
- ☐ Stroke
- ☐ Migraines
- ☐ Nervous Condition

GASTROINSTESINAL
- ☐ Ulcers
- ☐ Hiatal Hernia
- ☐ Reflux
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ IBS

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid
- ☐ Dysfunctions
- ☐ Hypoglycemia

LUNGS
- ☐ Asthma
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Pulminary Embolisim

OTHER ______________________

Date of last exam with Primary Care Provider: ______ /______ /______

What is your FOOT problem? ☐ RIGHT ☐ LEFT (Check one & explain):

____

____

____

When did it start? ______________________

____

		LEAST PAIN						MOST PAIN		
Rate Your Pain (circle)	1	2	3	4	5	6	7	8	9	10

Describe any accident or event involved with injury:

____

____

____

When was your first visit to a doctor for this problem?

____

____

Signature of patient required *Date*

____

(If Patient is a Minor, Signature of Parent or Legal Guardian is Required) *Date*