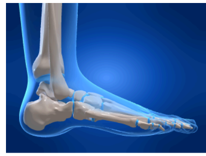


RIVERA
FOOT&ANKLE

PATIENT DEMOGRAPHIC INFORMATION

Full Name: ____

Date of Birth: ______________________________ Sex : ___ F ___ M

Address: ____

____

City:______________________ State:______________Zip Code:_________

Social Security:________________ Phone:_______________ Cell:________________

Work Phone:______________________________ Extensión:___________

Email: ____

Language: ________________ Race/Ethnicity:______________ Prefer not to report ___

Marital Status: ___ Single ____ Married ___ Separated ___ Divorced ___ Widowed

Employer:__________________________ Occupation: ________________________

Do you have a legal guardian or a healthcare power of attorney? YES ___ NO ____

If Yes, Name: ____

Relationship:____________________________ Phone: _________________________

Emergency Contact:____

Relationship:______________________________ Phone: _______________________

Primary Care Doctor:____

Who referred you to us? ____

Pharmacy: ________________________________ Phone:________________________

Location: ____

Would you like to share your medical information with someone? ___ YES ___NO

Name: ____

INSURANCE INFORMATION

Insurance Company Name:____

Insured's Name:____

Insured's Date of Birth: _________________________ Social Security: ______________

CURRENT PROBLEM

What brings you to our office today?____

How long have you had this issue?____

__ Dayss Weeks Months Years

What type of pain are you experiencing?

__ No Pain __ Sharp __ Dull __ Aching __ Burning __ Radiating __ Itching __ Stabbing

On a scale of 1 to 10, how intense is your pain?

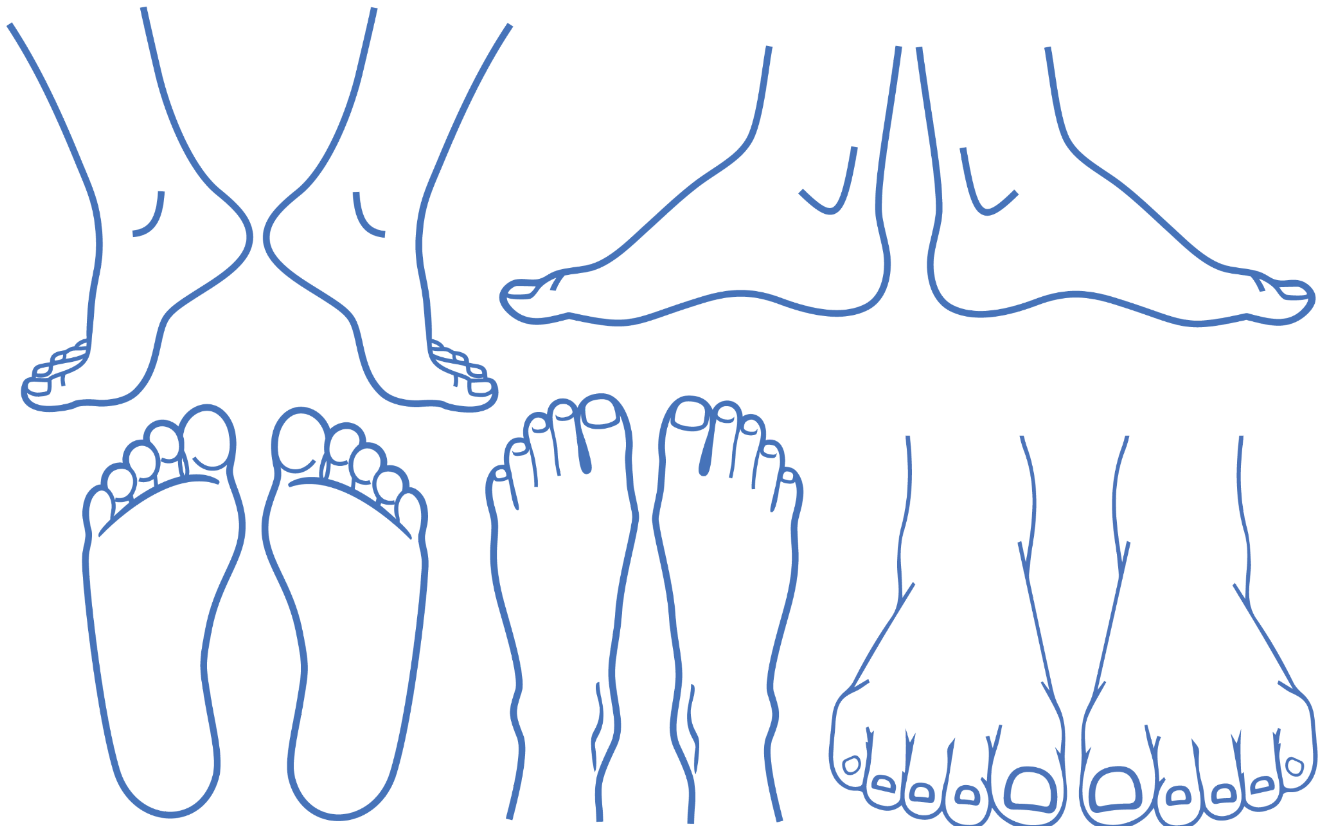
__ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10

What treatments have you had for this issue before?________________________________

Was this issue caused by an injury? __ Yes __ No

If yes, was it a work-related injury? __ Yes __ No

Where do you feel pain? **Please mark it on the picture below:**



MEDICAL HISTORY

Allergies: __ Medication(s) __ None. Specify: ____

Do you smoke?: __ YES __ NO   If you don't smoke, have you smoked before?: __ SI __ NO

Have you had a flu vaccine?: __ YES __ NO   When?:______________________________

If you are over 65 years old,

Do you have your pneumonia vaccine? __ YES __ NO   When?:__________________________

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

__ Anemia	__ Diabetes	__ Kidney Disease	__ Abnormal Bleeding
__ Arthritis	__ Fibromyalgia	__ Liver Disease	__ Stomach Ulcers
__ Asthma	__ Gout	__ Neuropathy	__ Stroke
__ Blood Clots	__ Hearth Attack	__ Open Sores	__ Thyroid Disease
__ Blood Transfusions	__ Hepatitis	__ Pneumonia	__ Tuberculosis
__ Cancer	__ HIV / AIDS	__ Skin Disorder	__ Cancer

Are you currently under care for pain management? __ YES __ NO

Have you been under pain management care in the past? __ YES __ NO

If yes, please provide the name of your pain management doctor:

____ Phone: ____________________

Height: ___________ Weight: ___________ Shoe Size: ___________

Please list the surgeries you have had along with their dates::

Type of Surgery: ____ Date: ______________

Type of Surgery: ____ Date: ______________

List of other hospitalizations you have had *(Other than for Surgery)*

Reason for stay: ____ Date: ______________

Reason for stay: ____ Date: ______________

LIST OF MEDICATIONS YOU ARE TAKING

Name	Dose	How often do you take them?
____________________________	_____________________	_________________________
____________________________	_____________________	_________________________
____________________________	_____________________	_________________________

MEDICAL HISTORY

MOTHER Alive?	YES	NO	Diabetes	Hypertension	Hearth Disease	Stroke	Mental Illness	Cancer	Arthritis
FATHER Alive?	YES	NO	Diabetes	Hypertension	Hearth Disease	Stroke	Mental Illness	Cancer	Arthritis
SIBLING Alive?	YES	NO	Diabetes	Hypertension	Hearth Disease	Stroke	Mental Illness	Cancer	Arthritis

Please be prepared to present your current insurance cards and driver's license at your initial visit and periodically during your time at the office.

- It is your responsibility to provide all updated demographic and insurance information.
- Failure to properly inform us of any insurance changes, will result in patient being responsible for any unpaid balance.
- Please note that while we verify your insurance benefits, verification of benefits is not a guarantee of payment.

It is your responsibility to understand the terms and conditions of your (or the insured) insurance coverage, including in-network/out-of-network, copayments and co-insurance responsibilities, benefits maximum and non-covered services.

- It is understood that your insurance company may not cover the full bill for the care received.
- If your insurance requires a referral, you are expected to be responsible for obtaining it unless instructed otherwise.
- Your visit may need to be rescheduled if there is not a proper referral at the time of your visit, as we are unable to get referrals after you have been seen.

In the event that my insurance company denies payment to us, or no insurance coverage is available to me, I agree that I will asure responsibility for payment of my account.

- Payment for services is due at the time of your visit. This may include co-payments, co-insurance, deductibles, and amounts for services that may not be covered by your insurance company.
- Should you not fulfill your financial obligations at the time service is rendered, your service may be rescheduled, as medically appropriate, to allow you to make the necessary financial arrangements.

To the best of my understanding, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

______________________________ ______________________________

Patient's Name, Parent, or Guardian *If you are not the patient, what is your relationship to the patient?*

______________________________ ______________________________

Signature *Date*

AUTHORIZATIONS

Benefits Assignment and Release of Information

YES __ NO __ I hereby authorize payment directly to the physician of the surgical and/or medical benefits.

YES __ NO __ I also understand I am responsible for any portion of my bill not covered by my insurance company.

YES __ NO __ The information authorized for release my include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

______________________ ______________________ ______________________

Date *Signature* *Guardian*

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and undestand the notice.

______________________ ______________________ ______________________

Date *Signature* *Guardian*