WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to helping you maintain your health.

PATIENT INFORMATION

Name:____**SS #**__________________
Last, First MI

Address____

City________________________________ **State**____________________ **Zip**____________

Home Phone (____)_______________________ **Work Phone (____)**___________________

Cell Phone(____)_________________________**E-Mail** ____________________________

Out of Town Address ____

____**Phone** _______________________

Sex • Male • Female **Age** _____________ **Birthdate** ____________________

Circle One: Single, Married, Widowed, Divorced, Separated

Patient Employed By:____

Address ____

City _______________________________ **State**______________________ **Zip**__________

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?

____

____

Have you ever been to a Podiatrist before? ______ **If yes,**
Name___________________________________ **Last Visit:** _________________________

Athletic activities in which you participate (please list and indicate frequency)

____

____

Please indicate which foot problems you now have or had in the past.

Ankle Pain	**Y N**	**Athlete's Foot**	**Y N**	**Bunions**	**Y N**
Corns/Calluses	**Y N**	**Cramps or Numbness**	**Y N**	**Flat Feet**	**Y N**
Foot or Leg Cramps	**Y N**	**Heel Pain**	**Y N**	**Ingrown nails**	**Y N**
Plantar Warts	**Y N**	**Swelling Ankles/Feet**	**Y N**	**Tired Feet**	**Y N**

MEDICAL HISTORY

(CIRCLE ALL THAT APPLY)

Diabetes
AIDS/HIV
Anemia
Angina
Arthritis
Artificial Heart Valve(s)
Artificial Joints
Asthma
Back Pain or Problems
Bleeding Disorders
Cancer
Chemical Dependency
Chronic Diarrhea
Circulatory Disease
Ear Problems
Emphysema
Epilepsy or Convulsions
Eye Problems

Fainting or Dizziness
Foot or Leg Cramps
Gallbladder Problems
Gout
Headaches
Heart Disease or Problems
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
Joint Pain or Stiffness
Kidney Problems, Stones or Dialysis
Liver Disease
Low Blood Pressure
Lung Problems
Mitral Valve Prolapse/ Heart Murmur

Nervous Disorder
Phlebitis or Blood Clots
Psychiatric Care
Radiation Treatment
Rheumatic Fever
Scarring Tendencies
Shortness of Breath
Sinus Problems
Skin Problems
Stomach Ulcers
Stroke
Swelling in legs or feet
Thyroid Disorder
Tired Feet
Tuberculosis
Varicose Veins
Weight loss, unexplained

Comments: ____
____
____

History or Current Use of Tobacco Use: ____

History or Current Use of Alcohol: ____

Surgeries you have had ____
____
____
____

Hospitalization other than for the surgeries listed ______________________________
____
____

Family Physician ______________________________ **Date of Last Visit** ____________

Whom may we thank for referring you to our office? ______________________________

Person to be Notified in Case of an Emergency __________________________________

Phone ____
Home Work

MEDICATIONS

Medication Name	Dosage/Frequency	Reason for taking

Do you take oral contraceptives? Yes No

Pharmacy Name(s) ______________________________

Pharmacy Phone(s)______________________________

ALLERGIES

(CIRCLE ALL THAT APPLY)

Adhesive/Tape	Anticoagulant Therapy	Aspirin
Codeine	Demerol	General Anesthetics
Iodine	Local Anesthetics	Penicillin
Seafoods	Sulfa	

Other ______________________________

Insurance

PRIMARY

Insurance Company ______________________________

Group #____________________ **Policy #** ____________________

Subscriber Name (if other than patient) ______________________________

Birthdate____________________ **SS #**____________________

Relationship to patient ______________________________

SECONDARY

Insurance Company ______________________________

Group # ____________________ **Policy #** ____________________

Subscriber Name (if other than patient) ______________________________

Birthdate____________________ **SS #**____________________

Responsible Party (if other than patient)
Person responsible for payment of services

____
Last Name, First Name MI

Relationship to Patient ______________________________ SS #_________________________

Address (if different from the patient): ____
Street/PO Box

____

____
City State Zip

Home Phone (____)_________________________ Work Phone (____)____________________

PERMISSION FOR TREATMENT

I hereby give my permission to Dr. Viedra Elison and/or Dr. Peyman Elison to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition(s).

____ ________________________
Signature Date

Lifetime Insurance Authorization to Release Information

I hereby authorize Dr. Viedra Elison and/or Dr. Peyman Elison and staff to release any information, for insurance purposes, required in the course of my examination and treatment.

____ ________________________
Signature Date

Agreement to Payment for Services Rendered

I, ____________________________,hereby authorize payment directly to the business office of Dr. Viedra Elison and/or Dr. Peyman Elison, for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

____ ________________________
Signature Date

Peyman A. Elison, D.P.M.
Viedra V. Elison, D.P.M.

14800 W. Mountain View Blvd
Suite 160
Surprise, AZ 85374
(623) 584-5556
(623) 584-0755 - fax

1175 W. Wickenburg Way
Suite 2
Wickenburg, AZ 85390
(928) 684-7227
fax - (928) 684-2300

Effective 6/1/03

We are committed to providing you with the best possible cost effective care; and in order to achieve this goal, we need your understanding and cooperation with our payment policy.

MEDICARE PATIENTS – This office accepts Medicare assignment. Medicare will pay our office directly. We will receive 80% of the allowed amount, minus your $100 deductible. Medicare regulations require us to bill and attempt to collect any amounts credited to your deductible and/or co-insurance.

Medicare determines what will be allowed for each service. No matter what is listed as our charge, we will receive no more than the Medicare payment, plus your payments of the remaining 20% and any amounts credited towards your deductible. Patients are responsible for payment in full of supplies or services not covered by Medicare.

Please note that Medicare identifies certain nail treatment, skin treatment, casts, bandages and wound dressings as "surgical care". Service Medicare may designate as "surgical" do not necessarily have to be an operation.

We bill all secondary insurances. If you do not have supplemental coverage, we will require that your 20% co-insurance amount be paid at the time of service. Any non-covered supplies or services must also be paid at the time of service, unless other arrangements are made in advance.

In the event that after Medicare and any supplemental insurance payment has been made and your account is left with a balance, that balance will be due from you within thirty (30) days. Statements will be sent out on a monthly basis. If your account is not paid in full within sixty (60) days, your account may be subject to interest charges or rebilling fees. There will also be a $15.00 charge on any checks returned by the bank.

If you have any questions regarding the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask. We are here to help you.

Dr. Peyman Elison
Dr. Viedra Elison

My signature below confirms that I have read the above statement regarding the payment policy and agree to abide by the contents thereof.

____ __________________________

Patient Signature **Date**

Peyman A. Elison, D.P.M.
Viedra V. Elison, D.P.M.

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MEDICARE LIFETIME AUTHORIZATION

Patient Name ______________________________ Medicare Number____________________

Authorization Period – Lifetime

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the provider named above for any bills for services furnished to me by that physician during the effective period of this authorization.

I authorize the above named provider to release any information needed for this claim or any related Medicare claim to the Social Security Administration or its intermediaries or carriers. I further permit a copy of this authorization to be used in place of the original.

If "other health insurance" is indicated in item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to insurer or agency shown.

I understand that the above named provider accepts Medicare assignment and agrees to accept the charge determination of the Medicare carrier as the full charge, and that I, the patient, am only responsible for any deductibles, co-insurance, and non-covered services or supplies as determined by the Medicare carrier.

Patient Signature ______________________________ **Date** ____________________