

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

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

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Wickenburg, AZ 85390
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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.

We will bill contracted insurance carriers. We require payment of your co-insurance, co-pay and/or deductible at the time of service.

If you are on an HMO-Gatekeeper Insurance Plan (Aetna, TriCare Prime, Mercy Care, AZ IPA, AHCCCS, etc.) it is your responsibility, as the patient, to obtain any necessary referrals or authorizations to be seen. Please keep track of expiration dates and number of visits allowed by referrals and authorizations, as you will be responsible for obtaining new referrals/authorizations upon their expiration. Many primary care physicians are now requiring up to ten (10) days notice to issue a referral or authorization.

If you are a self paying patient or wish to submit your own insurance, we will require payment in full at the time of service, unless other arrangements are made in advance. For larger balances, a monthly payment plan can be arranged prior to services being performed.

If, after 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. Balances not paid within thirty (30) days may be subject to service 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
And Staff

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