PATIENT REGISTRATION

Date _____

Name _____ Home# _____ Cell# _____

Address _____
Street Apt # City State Zip

Sex: _____M _____F Age _____ Birth date _____ Patient SS# _____

_____ Single _____Married _____Widowed _____Divorced

Occupation _____Employer _____Email: _____

Employer Address and Phone _____

Insurance _____

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's Employer _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Phone _____ Relationship _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Brett Roeder, D.P.M. (Phoenix Foot Surgeon Inc.) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

IF APPLICABLE, PLEASE COMPLETE:
MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Brett Roeder, D.P.M. (Phoenix Foot Surgeon Inc.), for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Brett Roeder, D.P.M.
1501 North Gilbert Road Gilbert AZ, 85234
Phone (480) 507-7560 Fax (480) 507-7509
GilbertFootSurgeons.com

MEDICAL HISTORY

Name _____ Date _____

Reason for today's visit:_____

Please indicate if you have had any of the following:

_____ AIDS/HIV
_____ Allergies to Anesthetics
_____ Allergies to Medicines or Drugs
_____ Angina
_____ Arthritis
_____ Artificial Heart Valves or Joints
_____ Asthma
_____ Back Problems
_____ Bleeding Disorders
_____ Cancer
_____ Chemical Dependency
_____ Chest Pain
_____ Circulatory Problems
_____ Diabetes
_____ Gout
_____ Heart Disease
_____ Hepatitis or Jaundice
_____ High Blood Pressure
_____ Kidney Problems
_____ Liver Disease
_____ Phlebitis
_____ Respiratory Disease
_____ Rheumatic Fever
_____ Shortness of Breath
_____ Stroke
_____ Thyroid Disease
_____ Other: _____

Cigarette/Tobacco use _____ Years smoked _____ Quit_____

Surgeries: _____

_____

Hospitalization: _____

_____

Family Physician: _____ Last visit date: _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? _____yes _____no

If yes, please explain _____

_____

Medications:_____

_____

Pharmacy Name: _____ Pharmacy Phone: _____

Allergies:

_____ Adhesive / Tape
_____ Anticoagulant Therapy
_____ Aspirin
_____ Codeine
_____ Demerol
_____ Iodine
_____ Local Anesthetics
_____ Novocaine
_____ Penicillin
_____ Seafoods
_____ Sulfa
Other _____

Consent:

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____