CANYON
FOOT + ANKLE

Patient Information Sheet

Social Security#:

First Name: _____ **Last Name:**_____ **Middle Initial:**_____

Date of Birth: (MM/DD/YYYY) **Age:** **Gender:** **Marital Status:**
_____ / _____ / _____ _____ ☐Male ☐ Female ☐Single ☐Married ☐Widowed ☐Divorced ☐Other

E-Mail Address:_____ **Would you like to receive emails?** **Yes** **No**

Mailing Address: **Apt.#:** **City:** **State:** **Zip:**

_____ _____ _____ _____ _____

Cell Phone:
(_____)_____ **Home Phone: (____)**_____ **Work Phone: (_____)**_____

Employer Name:_____ **Employer's Address / City / State / Zip** _____

Emergency Contact: _____ **Emergency Telephone #: (____)**_____ **Relationship:**_____

Primary Insurance Company Information:	**Secondary Insurance Company Information:**
Policy Holder's First Name & Last Name:	**Policy Holder's First Name & Last Name:**
_____	_____
Policy Holder's SSN: **Policy Holder's Date of Birth:**	**Policy Holder's SSN:** **Policy Holder's Date of Birth:**
_____ - _____ - _____ _____ / _____ / _____	_____ - _____ - _____ _____ / _____ / _____
Gender: **Relationship to Policy Holder:**	**Gender:** **Relationship to Policy Holder:**
☐Male ☐Female ☐Self ☐Spouse ☐Child ☐Other	☐Male ☐Female ☐Self ☐Spouse ☐Child ☐Other
Policy Holder's Address: ☐Same as patient	**Policy Holder's Address:** ☐Same as patient
_____	_____
City: **State:** **Zip:**	**City:** **State:** **Zip:**
_____ _____ _____	_____ _____ _____
Insurance's Name:	**Insurance's Name:**
_____	_____
Policy ID: **Group #:**	**Policy ID:** **Group #:**
_____ _____	_____ _____

Family Physician : _____

Pharmacy: _____

How did you hear about us? _____

_____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Payments: **Patients are responsible for all fees including missed visits and returned checks. Interest and late fees may apply on past due balances. Payment is expected at the time services are rendered. Payments must be arranged before treatment.**

☐ I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.

Today's Date:_____ Patient's Signature: _____

Podiatry History

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

_____

When did you notice the problem? _____
Any other concerns? _____
_____

Have you ever been to a Podiatrist before? ☐Yes ☐No
If yes, please list: _____

Is there any personal or family history of diabetes? ☐Yes ☐No

Your occupation _____
Activities in which you participate (frequency):

_____

_____

Please indicate which foot problem(s) you now have or have had:

Ankle Pain ……	☐Yes	☐No
Athlete's Foot ……	☐Yes	☐No
Corns and Calluses ……..	☐Yes	☐No
Cramps or Numbness in Feet or Legs …	☐Yes	☐No
Arch Problems ……..	☐Yes	☐No
Foot or Leg Cramps ……..	☐Yes	☐No
Gout …….	☐Yes	☐No
Heel Pain ……	☐Yes	☐No
Ingrown Toenails ……..	☐Yes	☐No
Plantar Warts ……	☐Yes	☐No
Swelling in Ankles or Feet ……	☐Yes	☐No
Tired Feet……..	☐Yes	☐No

What makes it better?

_____

_____

Medical History

AIDS/HIV	☐Yes ☐No	Circulatory Problems	☐Yes ☐No	Phlebitis	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Diabetes Type 1/Type 2	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Allergies to Medicine or Drugs **(PLEASE LIST BELOW)**	☐Yes ☐No	Ear Problem	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Latex	☐Yes ☐No	Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
Allergies to Penicillin	☐Yes ☐No	Eye Problem	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Headaches	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis	☐Yes ☐No	Heart Disease	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Artificial Heart Valves or Joints	☐Yes ☐No	Hemophilia	☐Yes ☐No	Special Diet	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Stroke	☐Yes ☐No
Back Problems	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cancer: **if so what kind?** _____	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Chest Pain	☐Yes ☐No	Mental Health Disorders	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐ No	Neuropathy	☐Yes ☐No	Alcohol Use	☐Yes ☐No
				How Frequent?	_____
Cigarette/Tobacco Use	☐Yes ☐ No	Other (please list):			

Surgeries/Hospitalizations Y / N **If yes, please explain** _____

Family Medical History (please circle)

Diabetes	Cancer	High Blood Pressure	Gout	Arthritis
Heart Disease/Attack	Birth Defects	Foot Problems	Stroke	Other _____

Medications

Include prescriptions, over-the-counter medications and vitamins: _____

_____

_____

Allergies

☐Adhesive/Tape	☐Local Anesthetics
☐Anticoagulant Therapy	☐Novocaine
☐Aspirin	☐Seafoods
☐Demerol	☐Sulfa
☐Iodine	☐Codeine
☐Other _____	☐No Allergies

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to provide podiatric services, and medicines, submit my insurance form, consider my signature "on file" for payment, and to release any & all records needed. I understand the privacy policy, and have read and understand the above and agree to be personally responsible for all charges & fees.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

2190 Village Park Ave St. 100
Twin Falls, Idaho 83301
Phone: (208)733-0436
Fax: (208)733-0438

CANYON
FOOT + ANKLE

382 N. Overland Ave.
Burley, ID 83318
Phone: (208)678-2727
Fax: (208)678-1477

Medical Records Release Form

By signing this form, I authorize Dr. Pilling's office to release confidential health information about me to the following members of my family or a designated guardian/POA.

Patient Name_____DOB_____

1. **_____ Relationship_____ Phone_____**
2. **_____ Relationship_____ Phone_____**
3. **_____ Relationship_____ Phone_____**

Patient Signature: _____Date:_____

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Payment Policy

We are happy to assist you in billing most insurance companies. However, we must emphasize that your insurance is a contract between you and your insurance company.

Many of the services provided in this office are covered and paid by your insurance company. In cases where the service has not been paid, you will be personally responsible for the balance. If the patient is a minor, then the person bringing the minor to the office for treatment is responsible for payment of the bill.

Payment for services, over the counter products and/or co-pays are due at the time services are rendered.
If you have not yet met your deductible you may be required to pay a portion of your visit at the time of your appointment.

Appointments not cancelled within 24 hours will be charged a $25 Fee.

We accept cash, checks and money orders.
We also accept Visa, Mastercard, Discover and American Express.
Account balances 90 days & over will be turned over to Bonneville Management Services.

Signature_____ Date_____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practice

The attached **Notice of Privacy Practices** contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. **Please refer to that Notice for further information.**

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (Please Print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature