CANYON
FOOT + ANKLE

Patient Information Sheet

Social Security#:

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

D.O.B (MM/DD/YYYY):_____ Age: _____ Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other

Email Address:_____ Would you like to recieve emails? ☐Yes ☐No

Mailing Address: Apt # City: State: Zip Code:

_____ _____ _____ _____ _____

Do you currently reside in an assisted living or care facility? ☐Yes ☐No If yes, which one?:_____

Are you currently receiving home health or hospice care? ☐Yes ☐No If yes, Company Name?:_____

Cell Phone: (_____) - _____ Home: (_____) - _____ Work: (_____) - _____

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

Emergency Contact: _____ Em. Phone #: (_____) - _____ Relationship:_____

Primary Insurance Information:

Policy Holder's First Name & Last Name:

_____

Policy Holder's SSN: Policy Holder's DOB:

_____ - _____ - _____ _____ / _____ / _____

Gender: ☐Male ☐Female Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Mailling Address: ☐Same as patient

_____

City:_____ State:_____ Zip Code:_____

Insurance's Name:

_____

Policy ID: Group #:

_____ _____

Secondary Insurance Information:

Policy Holder's First Name & Last Name:

_____

Policy Holder's SSN: Policy Holder's DOB:

_____ - _____ - _____ _____ / _____ / _____

Gender: ☐Male ☐Female Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Mailling Address: ☐Same as patient

_____

City:_____ State:_____ Zip Code:_____

Insurance's Name:

_____

Policy ID: Group #:

_____ _____

Family Physician: _____ Pharmacy: _____

How did you hear about us? ☐Google Search ☐Social Media ☐Newspaper ☐Radio ☐Phonebook ☐Family/Friend: _____

☐Doctor/Provider: _____ ☐Other: _____

I HEARBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIN AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENTS 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 expect at the time services are rendered. Payments must be arranged before treatment.

☐ **I have recieved the Confidentiality Agreement (HIPAA) and agree to comply with all its terms.**

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

Podiatry History

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

_____

When did you notice the problem? _____

Any other concern? _____

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 (frequently):

_____

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

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

What eases your discomfort?

_____

Medical History

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

Other (please list):_____

Are you pregnant, or is there a possibility that you may be pregnant? ☐ Yes ☐ No

Surgeries/Hospitalizations? ☐ Yes ☐ No If yes, please explain: _____

Family Medical History (check all that apply): ☐ 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

Please check all that apply:

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

_____

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 and all records needed. I understand the privacy policy, and have read and understand the above and agree to be personally responsible for all charges and fees.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

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

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 Canyon Foot+ Ankle 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:**_____

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.

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

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382 N. Overland Ave.
Burley, ID 83318
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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 120 days & over will be turned over to Bonneville Management Services.

Signature_____ Date_____