

Mendoza Foot & Ankle Center

Daniel Mendoza, DPM

Patient Demographic Information:

Name _____ Gender: Male Female SSN# _____ - _____ - _____

Date of Birth ____/____/____ Age ____ E-mail _____

Address _____

Street

City

State

Zip

Phone: Home _____ Work _____ Cell _____

Best number to call: (Circle one) Home Work Cell

Contact Preferences:

How would you like our office to contact you? Phone Mail E-mail

If by phone is it ok to leave a message with: Patient only Patient or Spouse Anyone

Emergency Contact:

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Primary Language: _____

Race: American Indian or Alaska Native

Ethnicity: Hispanic or Latino

Asian

Not Hispanic or Latino

Black or African American

Native Hawaiian or Pacific Islander

White

How were you referred to our office? _____

Responsible Party/ Primary Insurance Carrier (If not self):

Name: _____ Date of birth: ____/____/____

SSN# _____ - _____ - _____ Relationship: _____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Mendoza Foot and Ankle Center of any changes to the above information.

Patient or Guardian Signature: _____ **Date:** _____

History & Medical Information

1. Primary Care Physician: _____
Date of last visit: ____/____/____ Phone Number: _____
2. Explain your foot/ankle problem: _____
3. When did pain/discomfort begin?(date): _____
Describe pain/discomfort: Burning Numbness Sharp Other: _____
4. What makes the pain/discomfort better? _____
5. What makes the pain/discomfort worse? _____
6. Has the condition been treated?: YES NO When and how: _____
7. Height _____ Weight _____
8. Date of last Flu Shot ____/____/____

9. **Past Medical History:**

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disorders | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nerve Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neurological | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Osteoarthritis | |

10. List all Medications/herbs/vitamins: None

Pharmacy name: _____ Phone # _____

11. **Allergies:** None

- | | | |
|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Narcotic Agents | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Radiographic Contrast/Dyes | |

12. **Surgical History:** Have you had surgery? YES NO

Describe(surgery/date): _____

13. **Occupation/Job:** _____

14. **Social History:**

- Alcohol Use Caffeine Drug Use Exercise Habits _____ Nursing Pregnant

Tobacco Use(circle one): current everyday smoker current social smoker former smoker
never smoked smokeless tobacco user

15. **Family History:** (list relationship of member(s) who have had problems)

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatology | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | _____ |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/ Guardian Signature: _____ Date: _____

Review of Systems

1. Constitutional:

Chills Fever Sweats Weight Loss(intentional, unintentional) NONE

2. Head, Eyes, Ears, Nose and Throat:

Do you wear: Contacts Dentures Eyeglasses NONE
Do you have: Cataracts Difficulty Swallowing Dizziness Double Vision Neck Pain
 Nose Bleeds Ringing in Ears Sore Throat NONE

3. Cardiovascular:

Cardiovascular Surgery Chest Pain Congestive Heart Failure Heart Attack
Heart Murmur Leg Pain with Exercise Palpitations Swelling in Legs/ Ankles NONE

4. Hematological/ Lymphatic (blood):

Anemia Bleeding Abnormalities Lump in Groin or Armpit Lymphoma Swollen Glands NONE

5. Respiratory:

Asthma Bronchitis Cough Difficulty Breathing Pneumonia
Previous Pulmonary Disease Shortness of Breath TB (tuberculosis) Exposure or Treatment NONE

6. Gastrointestinal:

Acid Reflux Blood in Stool Constipation Decrease in Appetite Diarrhea
Hepatitis Nausea Stomach Ulcers Vomiting NONE

7. Endocrine:

Diabetes Kidney Disease Often Thirsty Often Urinating Pancreatitis
Prostate Problems Thyroid Disorder NONE

8. Musculoskeletal:

Arthralgia Broken Bones Bursitis Feeling Weak Joint Pain
Tendonitis Weakness of Limbs None

9. Nervous System:

Aphasia(loss of speech) Ataxia(loss of balance) Confusion Fainting Migraines
Nervous Disorders Neuropathy(loss of sensation) Seizures Speech Difficulties
Strokes NONE

10. Integumentary:

Change in Skin Color Cracking of the Skin Eczema Growth on Skin Hair Loss
Keloid Lesions Rash Recurrent Infections
Sensitivity to Sun Skin Ulcers NONE

11. Psychiatric:

Anxiety Depression Nervousness Tension NONE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/ Guardian Signature: _____ Date: _____

Assignment of Benefits and Financial Agreement

Mendoza Foot and Ankle Center

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependant to be made directly to Mendoza Foot and Ankle Center. This authorization is valid until I notify Mendoza Foot and Ankle Center in writing that it is revoked.

I understand that I am responsible for giving "Mendoza Foot and Ankle Center" the correct insurance information at the time services are rendered. Mendoza Foot and Ankle Center agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Mendoza Foot and Ankle Center is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Mendoza Foot and Ankle Center expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a \$10 re-billing fee for each statement that we mail. If you have made arrangements with our office, we will not charge the re-billing fee for statements sent. Your account will be turned over to collections if you do not fulfill the terms of your financial arrangements.

I understand that there is a \$30 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a \$25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, copay, co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and or court costs incurred by this office.

Patient or Patients Guardian or Legal Representative Signature

Date

Name of Patient or Guardian or Legal Representative

Relationship to patient

ACKNOWLEDGEMENT OF RECEIPT 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

**** Packets are available at the front window**