

Mendoza Foot and Ankle Center

Daniel Mendoza, DPM
**Diplomate, American Board of Podiatric Surgery*

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Apt. # City State Zip

S.S. #: _____ - _____ - _____ Sex: MALE FEMALE

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

E-mail: _____

Emergency Contact:

Name: _____ Relationship: _____

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

Responsible Party/Primary Insurance Carrier (If Not Self):

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____
Street Apt. # City State Zip

S.S. #: _____ - _____ - _____ Sex: MALE FEMALE

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

Employer: _____ Employer Phone: () _____

How were you referred to our office?: _____

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: _____

Gallatin • 336 Summer Hall Dr., Gallatin, TN 37066 • (615) 452-8899
Nashville • Skyline Medical Plaza, 3443 Dickerson Pk., Suite 500, Nashville, TN 37207 • (615) 860-8282

“We, Mendoza Foot and Ankle Center, are pledged to improve the quality of life through treatment of foot and ankle disorders. Our team is committed to a relationship based upon care, concern and compassion. We will always strive to enjoy what we do.”

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 collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a fee \$25 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, co-pay, and 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

Review of Systems

Mendoza Foot and Ankle Center

1. Constitutional Symptoms:

Fevers Chills Sweats Weight Loss NONE

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

Wear:	Contacts	Dentures	Eyeglasses	NONE
Have:	Double Vision	Cataracts	Dizziness	Ringing in Ears
	Difficulty Swallowing	Neck Pain	Sore Throat	
	Nose Bleeds	NONE		

3. Cardiovascular:

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

4. Hematological/Lymphatic (blood) History of:

Bleeding abnormalities	Anemia	Lump In Groin or Armpit	Lymphoma
Swollen Glands	NONE		

5. Respiratory:

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

6. Gastrointestinal:

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

7. Endocrine:

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

8. Musculoskeletal:

Tendonitis	Bursitis	Broken Bones	Arthralgia
Weakness of limbs	Feeling Weak	Joint Pain	NONE

9. Nervous System: History of...

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

10. Integumentary:

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

11. Psychiatric: History of...

Nervousness	Tension	Depression	NONE
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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: _____



Doctor's Review; Doctor Signature: _____

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

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