

No. _____

**ALBUQUERQUE
ASSOCIATED PODIATRISTS**

DATE: _____

Welcome To Our Office
(PLEASE PRINT)

CONFIDENTIAL PATIENT INFORMATION

AGE: _____

DOB: _____

Patient _____
(last name) (first name) (middle initial) (social security number)

Single Married _____
husband's or wife's name (if minor, parent or guardian's name)

Address _____ Phone _____ Cell _____

City _____ State _____ Zipcode _____

Height: _____ Weight: _____ Shoe Size: _____ Email: _____

Employed By _____ Occupation _____

Business Address _____ Phone _____
(street) (city) (zip code)

Spouse Employed By _____ Occupation _____

Business Address _____ Phone _____
(street) (city) (zip code)

In Case of Emergency Notify _____ Phone _____

Name(s) of Your Medical Insurance Company & Number(s) of Your Policy(s): _____

Whom May We Thank For Referring You To This Office? Name _____

Address _____

Family Physician _____ Last Visit _____

Former Podiatrist _____ Last Visit _____

What is your chief foot complaint? _____

Duration? _____

Last Physical Examination _____

Do you have Diabetes? Yes No Borderline Date/Reading of Last Blood Sugar? _____

Do you smoke? Yes No How many packs per day? _____

Have you had any operations? (What and When?) _____

What medicines do you take? _____

Is there any family history of Diabetes Cancer Foot Deformity

If you have or have had any of the following, please check:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Foot Ulcer | <input type="checkbox"/> Circulation Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Broken Bones (foot/leg) | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Swelling (ankle/foot) | <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Cramps (foot/leg) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV | |
| <input type="checkbox"/> MRSA History | <input type="checkbox"/> Other, specify _____ | | |

Are you Allergic or Sensitive to:

- | | | |
|--|--|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Adhesive Tape |
| <input type="checkbox"/> Keflex | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Other, please specify _____ | |

THANK YOU

I hereby give my permission to administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

SIGNATURE X _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
_____ and assign directly to Dr. Mark Haas / Dr. Zachary M. Haas
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 the payment of benefits. I authorize the use of this signature on
all insurance submission.

X

RESPONSIBLE PARTY SIGNATURE

Relationship _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to
Dr. Mark Haas / Dr. Zachary M. Haas 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 it's
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 HCFA-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 noncovered services. Coinsurance and the
deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date