



DR MICHAEL DERSHOWITZ / DR GREG LOO / DR GREGG KRAHN / DR DAVID LEE

Patient \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_

Email \_\_\_\_\_ Fax Phone (\_\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Age \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_

How did you hear about our office? Check one:

- Doctor     [www.ArizonaPodiatry.com](http://www.ArizonaPodiatry.com)     [www.LeePodiatry.com](http://www.LeePodiatry.com)     [www.Southwestfootinstitute.com](http://www.Southwestfootinstitute.com)
- Magazine     Google     Yahoo     Television     Friend/family
- Other: \_\_\_\_\_

Primary or Referring Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Patient Employer \_\_\_\_\_ Occupation \_\_\_\_\_

***It is your responsibility to give us the correct billing information or you will be billed. Please make sure you give our receptionist your insurance card so we can scan it into our system!***

**Primary** Insurance Company \_\_\_\_\_

ID or Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Are you the Policy Holder? \_\_\_\_\_ If not, please note who is \_\_\_\_\_

Policy Holder relationship to patient \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

***We only accept Secondary Insurance coverage if MEDICARE is your primary!!***

**Secondary** Insurance Company \_\_\_\_\_

ID or Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Are you the Policy Holder? \_\_\_\_\_ If not, please note who is \_\_\_\_\_

Policy Holder relationship to patient \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES IN YOUR INSURANCE. FAILURE IN DOING SO MAY RESULT IN CLAIMS NOT BEING PAID AND YOU BEING BILLED FOR THE ENTIRE BALANCE.**

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above plan(s) and hereby assign all insurance benefits, if any, otherwise payable to me, directly to **SOUTHWEST FOOT INSTITUTE** for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



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**INSURANCE/BILLING/COLLECTIONS POLICIES  
(as of 7/18/06)**

We must emphasize that as a health care providers, our relationship is with you, our patient, and **NOT** with your insurance company. As a courtesy to you and per our contract with your insurance company, we will bill them directly assuming you have given us all your insurance information. We charge what is usual and customary for our area. The patient is responsible for any remaining unpaid charge as determined by your insurance company.

***You are responsible for knowing what your insurance benefits are, with regards to what insurance will and will not pay for. If you are in doubt, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. Please understand that payment of your bill is considered part of your treatment.***

We accept Visa, Mastercard, Discover, and American Express as well as debit cards, cash, and personal checks drawn on American funds.

We require all copays to be paid at the time services are rendered as indicated in our contract (and yours) with your insurance carrier.

We do offer payment plans for outstanding balances due, not for copayments. Please call our billing department to work that out. **Any accounts sent to collections will be charged an additional 33% -50% fee of the total balance.**

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**Children of divorced/separated parents**

Unless you give us a signed, notarized court order to keep on file, the parent or guardian who brings the child in for their office visit will be considered ultimately financially responsible. We will entrust you to tell our billing dept. who the bill needs to be sent to for any remaining balance after your insurance pays.

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We thank you for understanding our financial policies. This has become necessary in order to continue to accept your insurance plans without having to bill you upfront. Our goal is to make your visit with us as pleasant and professional as we can. If you have any questions, please feel free to ask or call our billing dept. for assistance. Thank you again for choosing us for your foot/ankle care.

*I understand these policies and agree to be bound by their terms. I also understand that such terms are subject to change or be amended and I will be notified of any such changes or amendments.*

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Patient/Guardian or Parent

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Date

SOUTHWEST  
foot institute™

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PATIENT \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SHOE SIZE \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

MEDICAL HISTORY

Please mark all that apply

- DIABETIC
- HYPERTENSION
- HEART DISEASE
- LUNG DISEASE
- LIVER DISEASE
- INFECTIOUS DISEASE
- ARTHRITIS
- HEPATITIS
- GOUT

OTHER: \_\_\_\_\_  
\_\_\_\_\_

ALLERGIES TO MEDICATIONS

Please mark all that apply

- NONE
- ASPIRIN
- PENICILLIN
- SULFA
- IODINE
- CODIENE
- CORTISONE
- TAPE
- GLOVES-LATEX
- OTHER \_\_\_\_\_

CURRENT MEDICATIONS

PAST SURGERIES (past 10 years)

- |          |          |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |
| 5. _____ | 5. _____ |

What foot/ankle problem brought you to our office today? \_\_\_\_\_  
\_\_\_\_\_

How long has this problem been present? \_\_\_\_\_

Have you had any treatment? \_\_\_\_\_

If yes, who performed the treatment? \_\_\_\_\_

Is the problem the result of an injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is the date of injury? \_\_\_\_/\_\_\_\_/\_\_\_\_

Where did the injury occur? \_\_\_\_\_

If the injury occurred at work, has your employer been notified? \_\_\_\_\_