

SWEENEY FOOT AND ANKLE SPECIALISTS
HELLO- WELCOME TO OUR OFFICE!
PLEASE FILL OUT ALL INFORMATION COMPLETELY

Personal Information Date _____

Name _____

 Last First Middle Initial Language spoken
Home Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell _____

Email _____ May we leave phone messages Y or N

SS# _____ Gender: M ___ F ___ Marital Status _____ Race _____ Ethnicity _____
(i.e. White, Asian, Hispanic) (Hispanic, Latin, other)

Date of Birth _____ Age _____ Weight _____ Height _____ Shoe Size _____

Employer Name _____ Address _____

Work Phone# _____ Ext _____ Occupation _____

Spouse/Parent/Guardian Name _____

Spouse/Guardian Employer _____ Work # _____

Spouse/Guardian SS# _____ DOB _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone# _____

Whom may we thank for referring you to our office _____

Medical History

What is the reason for today' visit _____

Name of Family Physician _____ Phone # _____ Last Visit _____

Have you been seen by a foot specialist prior to today _____ Name of this specialist _____

Please list ALL Medications you are taking _____

Please list any drug allergies _____

Please list all previous surgeries (including dates) _____

Have you ever had the following? (Please circle)

- | | | |
|---------------------|---------------------------|---------------------|
| Y N Liver Problems | Y N Stomach Ulcer | Y N Epilepsy |
| Y N Tuberculosis | Y N Difficulty in Healing | Y N Rheumatic Fever |
| Y N Kidney Problems | Y N Shortness of Breath | Y N Heart Problems |
| Y N HIV | Y N High Blood Pressure | Y N Diabetes |

Please list any other health issues not listed in above list _____

Do you smoke? ___ Do You Drink? ___ Pharmacy _____ Location _____ Ph# _____

*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 so chose) and understood the Notice. This notice has been posted to our website and is available at our facility in our waiting area.*

Signature of Patient or Parent or Authorized Rep. _____

Date _____

Office and Financial Policies: Please read and initial

When you make an appointment with our physician it is our policy to call your insurance carrier and verify eligibility and basic benefits. If your plan requires that you have a referral prior to seeing a specialist, please present this referral to the front desk before your visit with the physician. If you do not have your referral with you for this appointment, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full.

Insurance is a contract between “You and your Insurance Carrier”. As a *courtesy* to you, we will gladly file your insurance claim on *your* behalf. We allow **45 days** from the date a claim is filed for the insurance company to pay the claim. If the insurance carrier does not pay within this time, you will be responsible for the entire balance. We will be happy to review the benefits we have obtained with you. **You will be responsible for your deductible and co pay.** These items are due at the time of visit.

An “Insurance Waiver” maybe required acknowledging understanding of your responsibility for paying for non-covered services. Some insurance carriers arbitrarily refuse to cover certain services. Please be prepared to pay for these services in full or make financial arrangements with our front desk.

We require a 24 hour advance notice if you must cancel your appointment. Our office assistant will call you 24 hours prior to your appointment to confirm the date and time of your appointment. A missed appointment may be subject to a minimum of \$25.00 charge.

** ____ I authorize the release of any medical records from another provider, for the continuance of care, to Dr. D. Sean Sweeney. Witness name _____ and date.

**** ____ I have read the above office financial policies and I understand these policies given to me by Sweeney Foot and Ankle Specialist.**

** ____ I authorize payment of Medical Benefits to be made on my behalf to Sweeney Foot and Ankle Specialist for any services furnished to me. I authorize the release of any medical information held by Sweeney Foot and Ankle Specialist to the healthcare financing administration and its agents to process my claims.

**I HEREBY GIVE MY PERMISSION FOR TREATMENT.

_____ Date _____

** Please initial and sign, these items are required.