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____

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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.*

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Signature of Patient or Parent or Authorized Rep. Date

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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.