•Bring your INSURANCE CARD and CO-PAY to your visit•

Utah Foot Care

David H. Jaramillo, D.P.M.
Foot & Ankle Specialist

PATIENT INFORMATION:

Patient Full Name_____

Address_____

City_____State_____Zip_____

Home # (_____)_____Age_____

Cell # (_____)_____ Sex: ❑M ❑F

Date of Birth_____/_____/_____ Marital Status_____

E-mail Address _____

Social Security No. _____-_____-_____

Employer_____

Work # (_____)_____

Name of Spouse_____

Spouse Employer_____

Spouse Work # (_____)_____

Primary Care Physician_____

Physician Phone # (_____)_____

EMERGENCY CONTACT:

Nearest relative not living with you_____

Phone #(_____)_____ Relationship_____

CONSULTATION:

Reason for today's visit _____

How did you hear about us? _____

Referring Doctor _____

*If work related accident/injury, complete the following:

Date of Injury _____/_____/_____

Insurance Carrier _____

Claim #_____

Claim Adjuster_____

FAMILY INFORMATION: * *Complete if you're **under 18** or a **student***

Mother's Name _____

Address *(if different)*_____

City_____State_____Zip_____

Home # (_____)_____ Cell # (_____)_____

Father's Name _____

Address *(if different)*_____

City_____State_____Zip_____

Home # (_____)_____ Cell # (_____)_____

INSURANCE INFORMATION:

Is the patient covered under Medical Insurance? ❑ YES ❑NO

Primary Insurance

Insurance Name_____

Address_____

Phone# _____

Policy ID#:_____

Subscriber Name:_____

Subscriber's Date of Birth_____/_____/_____

Subscriber's relationship to patient_____

Secondary Insurance

Insurance Name_____

Address_____

Phone# _____

Policy ID#:_____

Subscriber Name:_____

Subscriber's Date of Birth_____/_____/_____

Subscriber's relationship to patient_____

(***Please Initial)***

X _____ I give permission to Dr. Jaramillo and his staff to discuss my medical treatment and billing with: _____

X _____ I was given the opportunity to read and/or receive a copy of the Privacy Policies for David H. Jaramillo, D.P.M.'s office.

X _____ I hereby give David H. Jaramillo, D.P.M. permission to examine and treat me.

PROMISORY NOTE: For value received I, the undersigned patient or guardian, promise to pay David H. Jaramillo, D.P.M. the assigned charges for treatment rendered together with billing charges, finance charges and collection fees. If 30 days lapse without payment, the account will be considered delinquent, and the account becomes due and payable in full. If legal action is required to collect the account, I agree to pay all costs, including attorney's fees.

PATIENT SIGNATURE **X** _____DATE_____

PARENT OR GUARDIAN SIGNATURE **X** _____DATE_____

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PATIENT MEDICAL HISTORY

Patient Name _____

1. Do you have any specific health problems such as:
   - ❑ Diabetes *If yes, are you currently taking insulin to control it?* ❑ Yes ❑ No
   - ❑ Arthritis ❑ High blood pressure ❑ Cancer ❑ Heart disease ❑ Other_____
2. Are you allergic to anything? ❑ Yes ❑ No if yes, what and what kind of reaction did you have? _____

_____

3. Please list any medications you are on such as prescription, over the counter, birth control or vitamins? _____

_____

4. Has anyone in your family (Mother, father, siblings, grandparents, aunt, uncle, etc.) had any of the following? If so, who?

   Arthritis:_____ High Blood Pressure:_____

   Cancer (what kind):_____ Osteoporosis:_____

   Diabetes:_____ Stroke_____

   Heart Attack:_____
5. What do you do professionally? _____
6. Have you ever used tobacco or alcohol? If yes, what is/was your level of consumption? _____

_____

7. Do you have any risk factors or any specific exposure to either the hepatitis or AIDS virus? ❑ Yes ❑ No

   If yes, what are they? _____
8. As a child did you ever have? ❑ rheumatic fever ❑ scarlet fever ❑ polio
9. Have you ever had any significant injuries, especially with long term complications? _____
10. Please list any surgeries you have had. Did you have any complications with the surgery, healing or the medications?

_____

_____

11. Has anyone in your family ever had a severe reaction to general anesthetic? _____

Review of Symptoms:

1. Do you wear? ❑ contacts ❑ glasses ❑ hearing aids ❑ loose or false teeth
2. Do you have a history of? ❑ cataracts ❑ glaucoma ❑ sinus infections
3. Do you get any of the following:
   - ❑ chest pain
   - ❑ shortness of breath
   - ❑ asthma
   - ❑ frequent heart burn
   - ❑ painful burning urination
   - ❑ problems with your bowel or bladder
   - ❑ joint pain
   - ❑ muscle pain
   - ❑ tingling
   - ❑ burning or numbness in any part of your body

Reason for Consultation:

What is bothering you with your feet? _____

Which Foot? _____ When did it start bothering you? _____

Please explain the exact area of pain _____

Can you describe the pain? (sharp, dull, throbbing, burning) _____

On a scale of 1-10 ten being the worst? _____

Have you done anything to treat this? If so, what? _____

Have you been to another doctor for this? If so, who? What was suggested to treat it? _____

_____

Did the treatment help? _____

Are there certain times of the day when it is worse? _____

Do you have any other related body symptoms? (back or leg aches)

_____

Is there anything else we should know to help with your diagnosis? _____

I, the patient, agree that this form was filled out to the best of my knowledge.

PATIENT SIGNATURE **X** _____DATE_____

PARENT OR GUARDIAN SIGNATURE **X** _____DATE_____

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Financial Policy

We are committed to provide you with the best possible medical care. Your understanding of our financial policy is important to our professional relationship. Please ask a staff member if you have any questions regarding our fees, financial policy or your responsibilities.

Insurance
Our office is filing insurance claims with an increasing number of insurance companies; therefore, it is impossible for us to keep record of your personal coverage. PLEASE READ YOUR INSURANCE CONTRACT TO UNDERSTAND THE BENEFITS AVAILABLE TO YOU. If you do not have your insurance card or proof of insurance, YOU WILL BE RESPONSIBLE TO PAY FOR YOUR VISIT AT TIME OF SERVICE.

Referrals
Some insurance require you to have a referral from your primary care physician for the time of service that you are seen. It is your responsibility to find out if you need a referral and to acquire that referral before you are seen.

Co-payments
YOU ARE REQUIRED TO MAKE CO-PAYMENTS AT TIME OF SERVICE. We accept cash, check, debit or credit card. If we have to bill you for your co-pay there will be a $20 charge. If your check bounces there will be a $20 fee added to your account.

Industrial Insurance
If your injury occurred at work, your regular insurance will not pay any claims. If you want your industrial insurance to pay for anything YOU ARE RESPONSIBLE TO PROVIDE US WITH THE NAME AND ADDRESSS OF THE INSURANCE COMPANY TO BE BILLED, A PHONE NUMBER TO REACH THEM, YOUR CLAIM NUMBER AND YOUR ADJUSTERS NAME.

YOU ARE RESPONSIBLE TO MAKE CERTAIN YOUR EMPLOYER FILES THE PROPER PAPERS WITH THE INDUSTRAIL CARRIER AND THAT THE CARRIER PAYS THOSE CLAIMS. If your case is being disputed with the industrial company, YOU ARE RESPONSIBLE TO MAKE PAYMENT IN FULL AND THEN SEEK REIMBURSEMENT WHEN YOUR CASE IS SETTLED.

Accounts Payable
A $15.00 fee will be added monthly to any account that is 60 days overdue until your account is paid in full.

Litigation
If you have a case in litigation, we require that fees are paid at time of service and then you are responsible to seek reimbursement when your case is settled.

Pre-Authorization for Out Patient Surgeries
Many insurance companies require pre-authorization on surgeries. We will pre-authorize your surgery with your insurance company. You are responsible to call them to confirm your benefits. Remember, pre-authorization is not a guarantee of payment.

By signing below you are agreeing to all terms and conditions explained to you in this document.

I certify that the above information is correct and authorize my insurance company and/ or David H. Jaramillo, D.P.M. to secure or release any information relating to any claims files. I understand that I am fully responsible for any bill in the event of nonpayment from the insurance company. I agree to pay cost of attorney fees, interest, service charges (late payment, insufficient funds, reasonable court costs, notes, etc.). I authorize insurance benefits to be paid to David H. Jaramillo, D.P.M.

I agree that any copy of this authorization shall be as valid as the original.

PATIENT SIGNATURE **X** _____DATE_____

PATIENT PRINTED NAME _____

PARENT OR GUARDIAN SIGNATURE **X** _____DATE_____