Ladislav Kuchar D.P.M.
Sarah Otero D.P.M.

DEMOGRAPHICS

PATIENT NAME:____

DATE OF BIRTH:__________ **SSN:**______________ **SEX:** ___ **MARITAL STATUS:** M S D W

ADDRESS:____

CITY:_________________________ **STATE:**____________ **ZIP :**__________

HOME PHONE:______________**CELL :**______________**WORK:**__________

CONFIRMATION CALL(circle one) VOICE CALL TEXT ENGLISH TEXT SPANISH NO CALLS

EMAIL:____

OCCUPATIONAL STATUS(circle one) EMPLOYED RETIRED STUDENT DISABLED NONWORKING

EMPLOYER/SCHOOL:____

EMERGENCY CONTACT:___________________________**PH:**_____________

DO YOU HAVE A LEGAL GUARDIAN OR POWER OF ATTORNEY? YES NO N/A
NAME:_________________________ PH:_________________________
RELATIONSHIP:____________________

PRIMARY INSURANCE

PRIMARY INSURANCE CARRIER NAME:________________________________
POLICY HOLDERS NAME:________________________ **DOB:** ___________
RELATIONSHIP: SELF SPOUSE CHILD OTHER:_______ **SSN:**________________
ID#:_________________________ **GROUP #:**________________________

SECONDARY INSURANCE

SECONDARY INSURANCE CARRIER NAME:______________________________
POLICY HOLDERS NAME:________________________ **DOB:** ____________
RELATIONSHIP: SELF SPOUSE CHILD OTHER:________ **SSN:**______________
ID#:_________________________ **GROUP #:**_______________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be assigned directly to the physician for services rendered. I understand that I am financially responsible for services not covered by my insurance company. I permit a copy of this authorization to be used in place of the original. I give my permission to Dr. Kuchar / Dr. Otero to provide medical treatment today and any future visits. I authorize disclosure of my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations. In an effort to provide a higher level of quality medical care Saguaro Podiatry Associates has adopted consolidated medication management. What this means to you is that; we electronically pull your existing prescriptions into our system from pharmacy systems across the nation through our physician management practice system. This allows us to monitor possible drug interactions, obtain your allergy history, increase accuracy, obtain accurate dosages and avoid duplicate prescriptions. As part of your HIPAA privacy and security we must have permission from you to access these records when signing this consent to treat you, you are also agreeing to this method of data collection of your pharmacy records.

_________________________________ ____________________
PATIENT/ GUARDIAN SIGNATURE DATE

Ladislav Kuchar D.P.M.
Sarah Otero D.P.M.

Payment Policy:

We are committed to providing you with the best care possible. Your clear understanding of our payment policy is important to us. Please ask if you have any questions or concerns about our fees, payment policy, or your payment responsibility. All patients must complete our Demographics form prior to seeing the physician. This is an annual requirement. It is your responsibility to notify us of any change of address or insurance coverage in a timely manner. Failure to do so could result in the full balance for services rendered becoming your financial obligation. Payments by cash, check, or credit card are accepted. If payment cannot be made at the time of service, prior arrangements will need to be made with the office. In the event you have not made any payments for services we rendered and/or attempted to make arrangements to make payments, we will consider your account to be delinquent. The office will turn it over to an attorney or collection agency and you will then be responsible for all charges and attorney fees incurred.

Your Insurance:

The office has made prior arrangements with some insurance companies and health plans to accept assignment of benefits. We will bill those plans for whom we have an agreement with and will only require you to pay the authorized co-payment, co-insurance or deductible at the time services are rendered. We have a contractual obligation with your insurance company to collect the copayment at the time of your appointment. If you have insurance coverage with a company we do not have a contractual agreement with, we will prepare and send the claim for you as a courtesy on an assigned basis. Please remember that your medical insurance is a contract between you and your insurance company. You are ultimately responsible for timely payment on your account.

Self Pay: (No Insurance)

All patients who are self-pay are expected to pay their balance in full at the time of service, unless other arrangements are made with the office.

Cancellation/No-Show Appointments:

We ask that you let the office know if you have to cancel or reschedule an appointment at least **24 hours in advance**. If notice is not given, you will be charged a $35.00 fee that is not covered by your insurance.

Returned Checks:

Saguaro Podiatry Associates, charges $35.00 for all returned checks.

________________________________ ________________________
PATIENT/ GUARDIAN SIGNATURE DATE

________________________________ ________________________
PRINTED NAME RELATIONSHIP TO PATIENT

MEDICAL HISTORY

Please PRINT the following information. This is important for your treatment.

Patient Name:____________________________Date of Birth:____________________Age:________
Family Physician:_________________________ Who referred you to us?_______________________
Pharmacy:_____________________Height:________Weight:_________Shoe Size:______________
DRUG ALLERGIES AND REACTIONS:____
Is this a work related injury or due to an accident? Yes___ No___ Please ask receptionist for work related injury questionnaire.

Are **YOU**, or have **YOU** ever been treated for : **PLEASE CIRCLE YES OR NO**

Diabetes	**YES**	**NO**	**Fibromyalgia**	**YES**	**NO**	**Stroke**	**YES**	**NO**
Neuropathy	**YES**	**NO**	**Epilepsy**	**YES**	**NO**	**Asthma**	**YES**	**NO**
Open Sores	**YES**	**NO**	**Heartburn/GERD**	**YES**	**NO**	**Liver Disease**	**YES**	**NO**
Eye Problems	**YES**	**NO**	**Restless Leg Syndrome**	**YES**	**NO**	**Blood Transfusion**	**YES**	**NO**
Hypertension	**YES**	**NO**	**Gout**	**YES**	**NO**	**Anemia**	**YES**	**NO**
Heart Disease	**YES**	**NO**	**Thyroid Problems**	**YES**	**NO**	**Prolonged Bleeding**	**YES**	**NO**
Varicose Veins	**YES**	**NO**	**High Cholesterol**	**YES**	**NO**	**Hepatitis**	**YES**	**NO**
Bad Circulation	**YES**	**NO**	**Kidney Disease**	**YES**	**NO**	**MRSA**	**YES**	**NO**
Blood Clots	**YES**	**NO**	**Dialysis**	**YES**	**NO**	**HIV**	**YES**	**NO**
Arthritis	**YES**	**NO**	**Cancer**	**YES**	**NO**	**Depression/Anxiety**	**YES**	**NO**
Rheumatoid Arthritis	**YES**	**NO**	**Are you pregnant?**	**YES**	**NO**			

Family History: (Please circle yes or no)
DIABETES: YES NO WHO_________RHEUMATOID ARTHRITIS YES NO WHO____________ HIGH BLOOD PRESSURE YES NO WHO_____________GOUT YES NO WHO_______________
NEUROPATHY YES NO WHO________________

Have you had more than two falls in the past year or one fall with injury in the past year?_______
How much are you on your feet on a daily basis?____
Do others depend on you for their care?____
Do you smoke?Yes___No___if yes how much?_________PAD. Previous smoker?________________
Do you drink alcohol?Yes___No___if yes, how much____
Do you exercise?Yes___No____How often________________Types of exercise__________________
Major Hospitalizations? When?____
Have you ever had foot or ankle surgery?Type of Surgery______________________________________
Do you have any disease, condition, or problem that you think the doctor needs to know about?____

Please Provide a list of your medication on a seperate sheet.

Signature:____Date:__________________________

If you are here for routine foot care and have no other complaints regarding your feet, you can Check here and stop here.

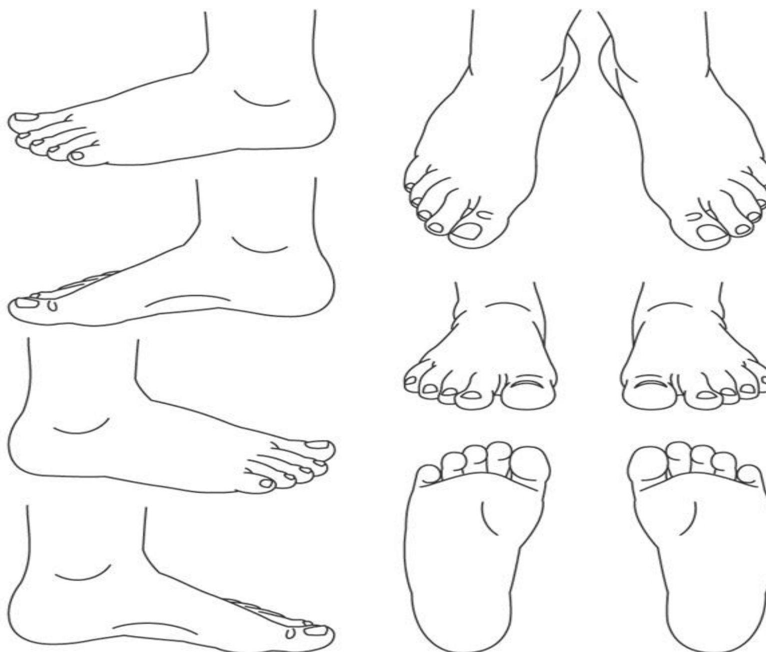
I am here for routine foot care ___YES ___NO

Problem List
What is your main foot complaint?

It Involves the ____Right Foot ____Left Foot ____Both Feet

Have you observed any signs of infection? ___YES ___NO
Redness ___YES ___NO
Swelling ___YES ___NO
PUS ___YES ___NO

Please mark the pain/problem area in the picture to the right:



How long has it been bothering you? ____

Did the pain or problem: ____begin all of a sudden ___Gradually developed over time

Describe your pain: ___NO Pain ___Sharp ___Dull ___Aching ___Burning ___Radiating

___Itching ___Stabbing ___Tingling ___OTHER (please describe) ___________________________

Rate your pain: 1 2 3 4 5 6 7 8 9 10 -worst pain possible

Since the problem began it: ___Has stayed the same ___Became worse ___Improved

What makes the problem Better? ____

What makes the problem worse? ___Walking ___Standing ___Running ___Daily Activities

____

What treatments have you had for this problem?____

____