Eulano Foot & Ankle, P.C.
Dr. Albert E. Eulano, D.P.M.
(480) 948-8754

PATIENT RECORD *Please fill out completely* *TODAYS DATE:* _____

Patients full name:

Last _____ First _____ MI _____ Sex M F

Patient SS # _____ Date of Birth _____ Shoe Size _____

Marital Status S M D W Name of Spouse _____

Phone Home _____ Work _____ Cell _____

Local Address _____

City _____ State _____ Zip _____

Second or out of state address _____

City _____ State _____ Zip _____

Pharmacy # _____ Email _____

Employer Name _____ Job Title _____

Company phone _____ Address _____

_____

How did you hear about us? _____

If referred, by whom? _____

Name of Family Physician _____ Phone _____

Address _____ Fax _____

Date last seen: Month _____ Day _____ Year _____

Person Responsible for payment if not covered by insurance:

Name _____ SS # _____

Address _____

Phone _____

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

SIGNATURE OF PARENT/RESPONSIBLE PARTY **DATE**

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MEDICAL HISTORY

Do you have a history of (please check box):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Heart Problems
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Stroke
- ☐ Phlebitis
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ Anemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Asthma
- ☐ Gout
- ☐ Rheumatic Fever
- ☐ Bursitis
- ☐ Poor Circulation
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emotional Problems
- ☐ Other serious illness: _____

Have you had any operations?

_____

_____

What childhood illnesses did you have?

_____

_____

Have you experienced any trauma, i.e. broken bones, automobile accidents?

_____

_____

Why are you here to see the doctor?

_____

_____

Have you had any previous treatment for this condition?

_____

If so, what?

_____

_____

Do you experience leg cramps? _____ **Low back pain?** _____
Stiffness in feet or legs? _____ **Numbness in feet or legs?** _____
Swelling of feet or legs? _____
Has anyone ever told you one leg is shorter than the other? _____
Do you have any problems healing? _____ **With scarring?** _____
Do you have any problems with prolonged bleeding? _____
When was your last physical? _____

Thank you for this information. It is vital in helping us to help you.

_____ _____

SIGNATURE OF PATIENT **DATE**

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INSURANCE INFORMATION

Name of Patient: _____
(please print)

Primary Insurance:
Medicare: YES ☐ **NO** ☐ **Medicare #** _____

Insurance Name _____

ID# _____ **GRP#** _____ **PLAN #** _____

Co-pay YES ☐ **NO** ☐ **Amount $**_____

Secondary Insurance:
Insurance Name _____

ID# _____ **GRP#** _____ **PLAN #** _____

ASSIGNMENT AND RELEASE:

I, the undersigned have _____ insurance, and assign directly to Dr. Albert E. Eulano all medical benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
SIGNATURE OF INSURED/GUARDIAN **DATE**

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to Dr. Albert E. Eulano for any services furnished to me by that physician. I authorize the holder of medical information about me to release to Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the DEDUCTIBLE, COINSURANCE and NON-COVERED SERVICES. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
SIGNATURE OF INSURED/GUARDIAN **DATE**

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Date: _____

Name of Patient:

_____

Reason for visit: Please indicate ☐ **LEFT FOOT/ANKLE** ☐ **RIGHT FOOT/ANKLE**

_____

_____

Experiencing Pain? **YES** _____ **NO** _____

Pain Scale (1 minimal to 10 worst)

Scale pain (1 to 10) _____

_____
Signature of Patient

Eulano Foot & Ankle, P.C.
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Date _____

Patient Name _____

List Current Medications OR see attached list:

_____

_____

_____

_____

_____

_____

_____

Do you smoke? ☐ **yes** ☐ **no**

Do you drink alcohol? ☐ **yes** ☐ **no**

What type? ☐ **wine** ☐ **beer** ☐ **hard liquor**

Medication Allergies:

_____

_____

_____ _____

PATIENT SIGNATURE **DATE**

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ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of this Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) **Date**

_____
Parent or Authorized Representative (if applicable)

_____
Signature

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Eulano Foot & Ankle, P.C. and its staff be handled in the following manner:

- For written communications: Address to: _____

  _____

  _____

- For oral communications: Call: _____
  (telephone number)

  May we leave a message?
  YES ☐ NO ☐

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____

_____

_____

_____
Patient Signature

_____
Date

FOR PRACTICE USE ONLY
PRACTICE: ☐ ACCEPTS ☐ DENIES

PRIVACY OFFICER SIGNATURE: _____ DATE: _____