Foot & Ankle Clinic

Dr. Orlando Nuñez, DPM, MD
Podiatric Surgeon
Fellow of the Academy of Ambulatory Foot and Ankle Surgery
Minimally Invasive Surgery

PATIENT INFORMATION FORM

Patient's Name _____ Date: _____
First Middle Last

Please Circle: Male Female Single Married Separated Divorced Widowed

Address _____
City _____ State _____ Zip Code _____
Date of Birth _____ Social Security # _____ Email _____
Phone/Home _____ Phone/Cell _____ Phone/Work _____

Employment Information
Employer _____ Occupation _____
Address _____
City _____ State _____ Zip Code _____

Spouse Information
Spouse Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Social Security # _____
Spouse's Employer _____ Occupation _____
Address _____
City _____ State _____ Zip Code _____

Please complete this section if the patient is not the person responsible for the bill
Person responsible for bill _____ Relationship _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Social Security # _____

Emergency Contact Information: In case of emergency who can our office contact?
Name _____ Phone Number _____

How did you hear about our office?

Circle: Instagram Facebook Phone Book Google

Other/Referred by: _____

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101 Ironwood Drive, Suite 131
Coeur d'Alene, ID 83814

(208) 666-0605
Fax: (208) 666-0916

cdafootandankle@gmail.com
www.cdafootankle.com

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FINANCIAL POLICY

Patient's Name _____ Date _____

As we see patients from many different insurance plans, it is impossible for us to know all the covered benefits, co-pays, and deductibles for each plan. In addition, your insurance company will not guarantee payment to us. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered or by Dr. Nuñez on your behalf are paid in full.

Patients Without Insurance Coverage
Payment in full at the time of service is expected unless you have worked out a payment plan prior to your visit. Patients on approved payment plans will be expected to pay at least ½ on the date of service and the remainder in a timely manner.

Co-Payment or Deductible
We will bill your insurance for you. Co-pays must be paid at the time of service, as require by your insurance company. Once your claim is processed by your insurance, any additional co-insurance deductibles, or non-covered services will be due upon receipt. If your insurance plan has an annual out-of-pocket deductible, you will be expected to make a payment that will be applied towards that limit at the time of service, and continue making payments until that deductible is met.

Orthotics and DME
There may be devices that Dr. Nuñez feels will be of benefit to you depending upon your condition that are not always covered by insurance plans. If this applies to you, we require that the orthotic, brace, etc. is paid for in full upon receipt since we cannot allow returns on these items.

Thank you for reviewing this information carefully. If you have any questions or need to establish a payment plan, please contact our office at (208) 666-0605.

PATIENT SECURITY

Please list below those that you would like us to be able to provide information to about your care. Without your authorization we will be unable to provide information about appointments, treatment plan, etc. This is for your security and is require by HIPAA. Thank you for your understanding.

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

ADVANCE DIRECTIVE

If you have a living will, or durable power of attorney for healthcare, you can provide a copy to the staff who will place the documents in your medical record. In Idaho, the Living Will and Durable Power of Attorney for Healthcare are obtained in one document. You may obtain Idaho State Advance Directive forms at:
https://sos.idaho.gov/hcdr/LivingWill_DurablePowerOfAttorney.pdf

Do you have an existing advance directive or living will? Yes No

Patient Signature _____ Date _____

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PATIENT HEALTH HISTORY

Patient Name _____

Allergies (medication allergies, seasonal/environmental allergies, and all other allergies)

_____

_____

Current Medications (prescription and over-the-counter)

_____

_____

Past Conditions or Diseases

_____

_____

Past Hospitalizations and Surgeries (include dates if possible)

_____

_____

Is this foot/ankle problem the result of a work injury or accident? Please Explain

_____

Personal Information

Height Shoe Size Weight

Have you had any previous foot surgeries? Yes No Have you previously been seen by a podiatrist? Yes No

Are you under the care of a physician now? Yes No Physician Name:

What is your foot problem?

Current sports or activities?

Patient Signature Date

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REVIEW OF SYSTEMS/MEDICAL HISTORY

General/Constitutional
- o Recent weight change
- o Pregnant
- o Cancer
- o Gout
- o Fatigue
- o Osteoporosis
- o Smoker – **Circle one:** Current Former Never
- o Excessive alcohol use
- o Substance abuse history

Eyes and Vision
- o Glaucoma
- o Eye disease or injury
- o Corrective lenses/contacts/glasses
- o Blurred or double vision

Ears, Nose, Throat, Mouth
- o Dentures, bridges, caps, loose teeth
- o Hearing loss
- o Ringing in the ears
- o Earaches or drainage
- o Sinus problems
- o Nose bleeds
- o Mouth sores or bleeding gums
- o Sore throat or voice change

Heart and Cardiovascular
- o Heart disease
- o Heart murmur
- o Heart attack
- o Heart defects from birth
- o Chest pains or angina
- o High blood pressure
- o Sudden heartbeat changes/arrhythmias
- o Swelling of the feet, ankles, hands
- o Rheumatic fever/rheumatic heart disease

Musculoskeletal
- o Arthritis
- o Back pain
- o Weakness of muscles/joints
- o Muscle pain or cramps
- o Difficulty in walking

Respiratory
- o Asthma
- o Lung disease (i.e. COPD)
- o Frequent coughing
- o Emphysema
- o Shortness of breath

Genitourinary
- o Kidney disease
- o Kidney stones

Skin and Breasts
- o Rash or itching
- o Change in skin color
- o Change in hair of nails
- o Varicose veins
- o Breast abnormalities (pain, lumps)

Psychiatric
- o Memory loss or confusion
- o Nervous breakdown or emotional problems
- o Depression
- o Sleep problems

Gastrointestinal and Liver
- o Liver disease (hepatitis, jaundice, cirrhosis)
- o High cholesterol
- o Loss of appetite
- o Abdominal pain

Neurological
- o Alzheimer disease or dementia
- o Frequent/recurrent headaches
- o Light headedness/fainting spells
- o Convulsions or seizures
- o Numbness or tingling sensations
- o Tremors
- o Paralysis
- o Stroke
- o Head injury

Endocrine
- o Diabetes
- o Thyroid disease
- o Glandular or hormone problem
- o Excessive thirst or urination
- o Heat/cold intolerance
- o Excessively dry skin

Hematologic/Lymphatic/Immunologic
- o Prone to infection
- o Autoimmune disease
- o HIV/AIDS
- o Slow to heal after cuts or prolonged bleeding
- o Easily bruise or bleed
- o Anemia
- o Phlebitis
- o Transfusion
- o Swollen glands
- o Blood disorders

Patient Name _____ Date _____

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HIPAA – NOTICE OF PRIVACY PRACTICES

This summary Notice of Privacy Practices contains a description of how our office and Dr. Orlando E. Nuñez will protect your health information and your rights as a patient. Please refer to the full notice for further information.

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process claims for services rendered to you. Finally, we may use and disclose your health information for assessment, licensing, accreditation, and training of students.

We will not use or disclose your health information without your written authorization except as stated in the Notice of Privacy Practices manual.

Patient Rights

As our patient, you have the following rights:

- To have access to and/or copies of your health information with a written consent and photo identification
- To receive information of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we amend your health information
- To receive a Notice of Privacy Practices

If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the HIPAA Privacy manual for the person or persons you may contact.

You have reviewed "Your Rights as a CDA Foot & Ankle Clinic Patient" printed above. Signing below acknowledges the receipt of the written Notice of Patient Rights.

Patient Name (Print) Date

Signature Parent or Authorized Representative (if applicable)

Insurance Information

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO *DR. ORLANDO E. NUÑEZ DPM, MD* FOR ANY SERVICES FURNISHED TO ME BY COEUR D'ALENE FOOT & ANKLE CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEAE TO THE CENTERS OF MEDICARE AND MEDICAID SERVICES, FORMERLY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE COMPANY

Signature Date