Swenson Foot & Ankle

5380 S. Rainbow, #318, Las Vegas, NV 89118 • (702) 873-3556 • Fax 702-871-4190

Dr. Grant Swenson

Name: _____ _____ _____
Last First MI Age Birthdate

Address: _____
Street City State Zip

Phone: (Home) _____ (Work) _____ (Cell) _____

M____ F_____ Social Security: _____ Marital Status: S M D W

Email Address: _____

Occupation: _____

Name & Phone of a Spouse or Relative: _____
Name Cell Number

Primary Care Physician: _____

Referred By: _____

Pharmacy Name & Address: _____

Pharmacy Phone: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic/Latino
❑ Native Hawaiian/Pacific Islander ❑ Unreported/Refused to Report ❑ White

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unreported/Refused to Report

Signature: _____ Date: _____

What foot problems are you having: _____

_____

Review of System
Circle Yes or No

Asthma	yes	no	Arthritis	yes	no
Emphysema	yes	no	Back Problems	yes	no
Shortness of Breath	yes	no	Cancer	yes	no
Pneumonia	yes	no	Epilepsy	yes	no
Persistent Cough	yes	no	HIV Virus	yes	no
High Blood Pressure	yes	no	Hepatitis	yes	no
Headaches	yes	no	Loss of Balance	yes	no
Numbness / Tingling	yes	no	Are you Pregnant?	yes	no
Stroke	yes	no	Stomach Problems	yes	no
Heart Attack	yes	no	Ulcers	yes	no
Chest Pain	yes	no	Bladder Problems	yes	no
Bleeding Disorders	yes	no	Diabetes	yes	no
Kidney Problems	yes	no	Blood Sugar #: _____		

Other Medical Problems: _____

Have you had any surgeries in the last 10 years? yes no

Explain: _____

Alcohol: no <2 4 6 Drinks per week. Smoke no <1 2 3 Packs per Day.

Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.)

_____

Allergic to:

Penicillin yes no **Sulfa** yes no **Adhesive Tape** yes no **Local Anesthesia** yes no **Latex** yes no

Allergic to other meds: _____

Medications now taking: _____

_____

Signature: _____ Date: _____

Swenson Foot & Ankle

Insurance Waiver

********** **PLEASE READ AND SIGN** **********

I AGREE TO ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES WHICH ARE DENIED BY MY INSURANCE COMPANY ON THE BASIS OF ELIGIBILITY, CO-PAYMENTS, DEDUCTIBLE, NON-COVERED ITEMS AND/OR PROCEDURES STATED AS MORE EXTENSIVE THAN THE INSURANCE WILL COVER, I ALSO UNDERSTAND THAT JUST BECAUSE MY INSURANCE COMPANY HAS CERTAIN BENEFITS I MAY BE RESPONSIBLE DUE TO THEIR DISCLAIMER. I ALSO UNDERSTAND THAT EVEN THOUGH ASSIGNMENT MAY BE TAKEN WITH MY INSURANCE COMPANY, I AM STILL RESPONSIBLE FOR ANY BALANCE NOT PAID BY MY INSURANCE WITHIN 60 DAYS OF THE DATE OF SERVICE. PLEASE UNDERSTAND IF THE ACCOUNT BECOMES DELINQUENT AND AN OUTSIDE AGENCY IS NEEDED FOR COLLECTIONS OF THIS ACCOUNT YOU THE PATIENT WILL BECOME RESPONSIBLE FOR ANY AND ALL COLLECTIONS OR LEGAL FEES. I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO SWENSON FOOT & ANKLE FOR SERVICES RENDERED.

SIGNATURE: _____ DATE: _____

Insurance Information

(If we have obtained copies of your insurance card you do not need to fill out the information, if insured is other than self, please fill in full name of insured and date of birth,)

Primary: _____ I.D. Number: _____

Full Name of Insured: _____ Relation to Patient_____ DOB: _____

Secondary: _____ I.D. Number: _____

Full Name of Insured: _____ Relation to Patient_____ DOB: _____

Fees

We expect all co-pays and deductibles to be paid at the time of service. If we are not a contracted provider for your insurance we will still bill them but payment in full is expected. Please remember that we only process claims in our system the way your insurance company has processed them. Any complaints or problems with the way claims are processed need to be taken up with your insurance company.

To the best of my knowledge I have supplied correct information to the above form and I have read and understand the FEES CLAUSE. I give permission to Dr. Grant Swenson to render the proposed podiatric examination and treatment that will be explained to me.

Insurance Payment Order

To: _____
(Insurance Company)

I authorize and direct you to pay directly to: Swenson Foot & Ankle, 5380 S. Rainbow Blvd., #318, Las Vegas, NV 89118, the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment or services by reason of such treatment or services rendered.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 choose) and understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representitive (if applicable)

_____
Signature