Dr. Orlando E. 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

Male Female Single Married Separated Divorced Widowed

Address ____

City ______________________________ State ______________ Zip Code ___________________

Home Phone ( ) _______________ Work Phone ( ) _______________ Cell Phone ( ) _________________

Date of Birth ________________ Social Security Number ________________ Email___________________________

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 Number ________________

Spouses Employer ____ Occupation ________________

Address ____

City ______________________________ State ______________ Zip Code ___________________

(Please complete this section if the patient is not the person responsible for the bills)

Person responsible for bills ____________________________________ Relationship ____________________

Address ____

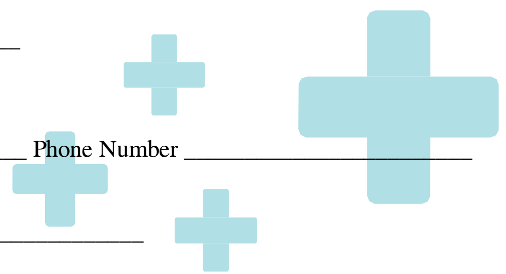
City ______________________________ State ______________ Zip Code ___________________

Home Phone ( ) _______________ Work Phone ( ) _______________ Cell Phone ( ) _________________

Date of Birth ________________ Social Security Number ________________

Emergency Information: In case of emergency who can our office contact?

Name ____ Phone Number ____________________



How did you hear about our office?

____

Verizon ________ **Hagadone**__________ **Local Pages**___________ **Google** ___________

101 Ironwood Drive • Suite 131
Coeur d'Alene, Idaho 83814
(208) 666-0605
Fax: (208) 666-0916
drnunez@cdafootankle.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. Nunez 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 required 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 be towards that limit at the time of service until that deductible is met.

Orthotics and DME
There may be devices that Dr. Nunez 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.

Nail Trims and Routine Foot Care
Due to insurance reimbursement restrictions, payments for nail trims or debridement are becoming subject to increasing limitations. Most insurances including Medicare will only pay for these services every 90 days. While the doctor is always available for acute foot care needs, the schedule typically only allows for routine foot care or nail debridement quarterly or once every 90 days. This service will be billed to your insurance company.

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.

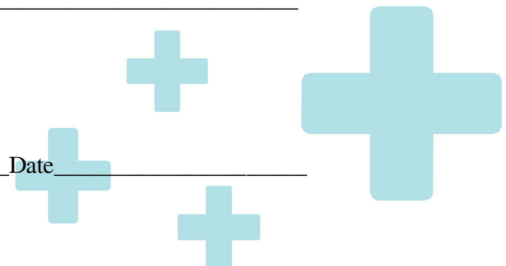
PATIENT SECURITY

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 required by HIPAA. Thank you for your understanding.

NAME____RELATIONSHIP__________________________________

NAME____RELATIONSHIP__________________________________

NAME____RELATIONSHIP__________________________________



Patient's Signature____Date____________________

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PATIENT HEALTH HISTORY

Patient Name: ____

- Please list any allergies you have to medications, and all other allergies:

____

____

- Please list current medications you are taking: prescription and over-the-counter:

____

____

- Past conditions or diseases:

____

____

- Please list 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 __________

Race __________________ Primary Language ___________________ Ethnicity____________________

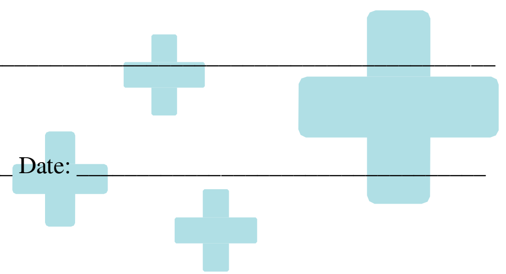
Previous Foot Surgery? **Yes** **No** Previously seen by a Podiatrist? **Yes** **No**

Are you under the care of a physician now? **Yes** **No** And Physician Name? ____

What is your foot problem? ____

Current sport or activities? ____

Signature: ____ Date: ________________________



Please continue filling out medical history on back

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Review of Systems / Medical and Family History Update

Family History of:

- O Cardiovascular disease
- O Cancer
- O Diabetes
- O Osteoporosis
- O Arthritis
- O Mental Illness

PLEASE CHECK ALL THAT APPLY IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

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 Wear glasses or contact lenses
- 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 mumur
- O Heart attack
- O Heart defects from birth
- O Chest pains or angina
- O High blood pressure
- O Sudden heartbeat changes
- O Swelling of the feet, ankles, hands
- O Rheumatic Fever / rheumatic heart disease

Psychiatric

- O Memory loss or confusion
- O Nervous breakdown or emotional problems
- O Depression
- O Sleep problems

Respiratory

- O Asthma or emphysema (**circle one if applicable**)
- O Lung disease (i.e. COPD)
- O Frequent coughing
- O Spitting up blood
- O Shortness of breath

Skin and breasts

- O Rash or itching
- O Change in skin color
- O Change in hair or nails
- O Varicose veins
- O Breast abnormalities (pain, lumps)

Musculoskeletal

- O Arthritis
- O Back pain
- O Joint pain, stiffness or swelling
- O Weakness of muscles/joints
- O Muscle pain or cramps
- O Difficulty in walking

Gastrointestinal and Liver

- O Liver disease (hepatitis, jaundice, cirrhosis)
- O Loss of appetite
- O Change in bowel movements
- O Nausea or vomiting
- O Frequent diarrhea
- O Painful bowel movements or constipation
- O Blood in stool
- O Abdominal pain

Neurological

- O Alzheimers disease or dementia
- O Frequent or recurrent headaches
- O Light headed or fainting spells
- O Convulsions or seizures
- O Numbness or tingling sensations
- O Tremors
- O Paralysis
- O Stroke
- O Head injury

Genitourinary

- O Kidney disease
- O Venereal disease
- O Frequent urination
- O Burning or painful urination
- O Blood in urine
- O Incontinence or dribbling
- O Kidney stones
- O Painful or irregular Periods

Endocrine

- O Diabetes
- O Thyroid disease
- O Glandular or hormone problem
- O Excessive thirst or urination
- O Heat or cold intolerance
- O Excessive dry skin

Hematologic/Lymphatic/Immunologic

- O Prone to infection
- O Autoimmune diseases
- 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

Patients Name: ______________________________ **Date:** ____________________

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HIPAA-NOTICE OF PRIVACY PRACTICES

This summary Notice of Privacy Practices contains s a description of how our office, and Dr. Orlando E. Nunez 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 this written Notice of Patient Rights.

______________________________	______________________________
Patient Name (please print)	**Date**
______________________________	______________________________
Signature	**Parent or Authorized Representative (if applicable)**

INSURANCE

LIFETIME INSURANCE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO *DR. ORLANDO E NUNEZ, 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 RELEASE 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 ____________________

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