Summit Foot + Ankle

4019 W 12600 S, Suite 120, Riverton Utah 84096
4578 S Highland Dr, Suite 380, Salt Lake City Utah 84117
801.253.6886 / 801.253.6888 Fax

Patient Information

Patient: ____

Age: ____________________ **Sex**: M / F **Date of Birth**: ____________________

Home Address: ______________________ **City**: __________ **Zip**: ___________

Home Phone: ______________________ **Cell Phone:**____________________

Work Phone: ______________________

Email Address: ____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Employer name/ School name: ____________________________________

Social Security Number: ____________________________________

Please list your family doctor: ______________ **Approximate date of last visit**: ________

Spouse's name or name of nearest relative (or parent if you are under 18): ______________

Relation: ________________ **Phone**: ________________

Address: ________________ **City**: ________________ **Zip**:__________

How did you hear about us?

☐ Google ☐ Doctors office ________________
☐ Facebook ☐ Friend ________________
☐ Instagram ☐ Mailer ________________
☐ Insurance ☐ Other ________________

I hereby authorize Ellsworth Foot and Ankle Clinic, LLC. to furnish my designated insurance carrier all the information concerning my present illness or injury. I authorize benefits under this claim to be made directly to the physician.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING:

A) I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance, in full, within 90 days of the date of billing. I agree to pay 18% interest per annum on the unpaid balance, compounded daily.
B) In the event that my account is not paid as agreed, I agree to pay a collection agency fee of 33.3% of my unpaid balance in addition to my balance, in the event that my account is delinquent.
C) If the account must be referred to an outside collection agency, and you have opted out of receiving a final notice for the delinquent account by text or email, a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to $6.00 will be added on top of the 33.3% collection fee when the balance is reported.
D) In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and costs of court and agree to submit to the jurisdiction of the Third Circuit Court, Salt Lake City, State of Utah.
E) If any portions of a bill for the provider's services are disputed, I agree to submit myself to mediation or arbitration and will pay the costs incurred in doing so.
F) We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by the telephone by sending text messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

Signed: ____________________________________ **Date**: __________

What is the nature of your foot complaint? ____
____
____

What have you done for this condition? ____
____

When does it hurt the most? ____

Approximately when did the condition start? ____

Are you generally in good health? Yes ☐ No ☐ Shoe size_______

If female, are you now pregnant? Yes ☐ No ☐ Weight_________

Past medical history – Do you have or have you had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Heart Disease / Heart Attack	☐	☐
Acid Reflux (GERD)	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Low Blood Pressure	☐	☐
Asthma	☐	☐	Nervousness / Anxiety	☐	☐
Back Problems	☐	☐	Rheumatic Fever	☐	☐
Bleeding Disorder	☐	☐	Seizures / Seizure Disorder	☐	☐
Cancer: ________________	☐	☐	Skin Problems: __________	☐	☐
Depression	☐	☐	Stroke	☐	☐
Gout	☐	☐	Thyroid Problems	☐	☐
Hayfever	☐	☐	Varicose Veins	☐	☐
Hepatitis	☐	☐	Other: __________________	☐	☐

Allergies

	Yes	No		Yes	No
Penicillin	☐	☐	Aspirin	☐	☐
Local anesthetics	☐	☐	Iodine	☐	☐
Sulfa	☐	☐	Tape / Adhesives / Latex	☐	☐
Codeine	☐	☐	Other: _________________	☐	☐

Please List the Medications You Currently Take: ____
____
____

Previous Surgeries: (all surgeries - include dates if possible): _________________________________
____
____

Family history (please circle if applicable):

Diabetes High Blood Pressure Heart Disease Bleeding disorder Anesthesia problems

Cancer: (what kind?) _________________________ Other: _____________________________

Social history:

Do you smoke? Yes ☐ No ☐ If no, have you smoked before? Yes ☐ No ☐

If yes, how many packs per day? _______________ How long? ______________

If you have quit, please indicate the date when: ____________________________

How often do you drink alcohol? Never ☐ Occasionally ☐ Moderately ☐ History of abuse ☐

Ryan Ellsworth, DPM
Summit Foot + Ankle

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Acknowledgement 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 chose) and understand the Notice.

______________________________ ______________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature

ALSO, may we leave messages on your home phone answering machine?

Circle one: YES / NO