GOLD CANYON FOOT & ANKLE

John Wayne McGhan, DPM

6804 S. Kings Ranch Rd, Ste #101
Gold Canyon, AZ 85118

Name:_____ **Date:**_____**Email**: _____

Address:_____

Home Phone:_____Work Phone:_____Cell:_____

Birthdate:_____**Age**:_____ Social Security #:_____ **Sex**:____Male____Female

Marital Status: ____S____M____D____W

Race: __ American Indian/Alaska Native __ Asian __ White __Hispanic __ Black/African American

Preferred Language:_____/ _____Patient Decline

Employer:_____Occupation:_____

Emergency Contact: Name:_____Phone:_____Relation:_____ (Outside of home)

Family Doctor:_____ Phone:_____Address:_____

Insurance Info: Do you plan to file Worker's Compensation? ____Y____N

Insurance Co.(**Primary**): _____Policy/ID#:_____

Policy Holder:_____Group#_____

Birthdate:_____SSN:_____Employer:_____

Insurance Co. (**Secondary**):_____Policy/ID#:_____

PolicyHolder:_____Group#:_____

PHARMACY & CROSS STREETS:_____

Medical History: _____**Diabetes** _____**Hypertension** _____**Heart Disease** _____**Lung Disease**

_____**Liver Disease** _____**Infectious Disease** _____**Arthritis** _____**Hepatitis** _____**Gout**

Other_____

ALLERGIES: ____None ____Aspirin ____Penicillin ____Sulfa ____Iodine ____Cortisone ____Tape ____Local Anesthetic

Other:_____

Tobacco: __No __Yes Type:_____ How long?_____

ShoeSize:_____**Height**:_____**Weight**:_____

Current Medications: **Past Surgeries (past 10 years):**

1._____1._____

2._____2._____

3._____3._____

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MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made to me or on my behalf to Gold Canyon Foot and Ankle for any services furnished me by that practice/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits payable to related services. I understand my signature below 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 the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination on the Medicare carrier.

Patient's Name: _____Medicare number _____

Patient's Signature: _____ Date:_____

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method bye the listed provider. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co pays, co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Patient Name: _____ Insurance Policy Number:_____

Patient Signature _____Insurance group number:_____