

WELCOME TO OUR OFFICE
www.AlaskaPodiatry.com

My appointment is with (circle one)

Dr. Swayman Dr. La Rose Dr. Fenn

Please Print

Patient Information

Patient's Name (FML)	Sex	Date of Birth (M/D/Y)	Age	SSN (even if child)
Street Address	City, State		Zip	Home Phone No
Mailing Address (If different)	Emergency Contact		Emergency No.	
Patient's or Parent's Employer	Occupation		Business Phone	
Employer's Address	City & State		Zip Code	
Spouse or Parent's Name	Address if Different		Phone No.	

Insurance Information

Person Responsible for Payment (If not above)	Social Security No.		Home Phone No.	
Street Address	City & State		Zip	Business Phone
Primary Insurance Co.	Subscriber #	Group #	Name of Insured	Relationship
Secondary Insurance	Subscriber #	Group #	Name of Insured	Relationship

Referred by _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient or responsible party is responsible for all fees, including any costs incurred in the collection of these fees, regardless on insurance. I understand that all outstanding balances are due after 60 days regardless of insurance status.

Insurance Authorization and Assignment (Please read and sign)

I hereby authorize Alaska Podiatry Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign them to all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature

Date

MEDICAL HISTORY

1. Please describe your foot problem _____
_____ Duration _____
2. Have you been under the care of a medical doctor in the past two years? YES NO
Physician's Name _____
3. Have you been in the hospital in the past two years? YES NO
4. Have you taken any medication or drugs during the past two years? YES NO
Please list _____
5. Are you allergic to, made sick by any drugs or medications? YES NO
Please list _____
6. Have you ever had any excessive bleeding requiring treatment? YES NO
7. Women: Are you pregnant now? YES NO
Do you anticipate becoming pregnant? YES NO
8. Please circle any of the following which you have had or have at present
- | | | |
|-----------|----------------------|-----------------------|
| AIDS | Heart disease/attack | Cancer |
| Diabetes | Allergies or hives | Drug addiction |
| Ulcers | High blood pressure | Rheumatic Fever |
| Anemia | Epilepsy/seizures | Fainting/dizzy spells |
| Stroke | Kidney disease | Varicose veins |
| Asthma | Liver disease | Blood clots |
| Glaucoma | Arthritis | Hemophilia |
| Hepatitis | Emphysema | Skin disease |
9. Do you have any disease, condition, or problem not listed?

10. Previous surgical procedures: _____
-

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or medications, I will inform the doctor at the next appointment.

DATE _____ NAME(print) _____ SIGNATURE _____

ALASKA PODIATRY ASSOCIATES
dba ALLIANCE FOOT & ANKLE

Kenneth C. Swayman, DPM
Susan K. Fenn, DPM
Carol F. La Rose, DPM

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Anchorage, AK 99508
907-562-4958

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of pertinent information to all my insurance companies.
- I understand that I am ultimately responsible for my bill.
- I understand all outstanding balances are due after 60 days regardless of insurance status.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Print Name: _____ SS# _____

Signature: _____ Date: _____