Southern Arizona Foot & Ankle Centers
IKE B. Gorman, D.P.M., F.A.C.F.A.S
Board Certified in Foot Surgery
7520 N. La Cholla Blvd Tucson, AZ 85741
P.O. Box 69040 Tucson, AZ 85737
(520) 722-5115/ FAX 520-722-0611

PATIENT REGISTRATION

Date: _____

Patient's Name: _____ , _____ _____
Last Name First Name SS/ID#

Physical Address: _____ City: _____ State: _____ Zip Code: _____
P.O. Box Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Marital Status M S W D (Encircle) Gender: M / F Date of Birth: _____ Age: _____

Occupation _____ Employer _____ Work Phone: _____

Work Address: _____ City _____ State _____ Zip code: _____

Spouse's Name: _____ Employer: _____ Work Phone: _____

Spouse's Social Security #: _____ Spouse's Date of Birth _____

Who referred you to our clinic? ( ) Yellow Page ( ) Friend ( ) Other ( ) Dr. _____

In Case of an Emergency, Contact: Name _____ Phone #: _____

Address _____ City _____ State _____ Zip Code: _____

Insurance Information for Patient: _____

Jnsurance Company: _____

Who is responsible for this account? _____ Relationship to patient: _____

ID# _____ GROUP # _____

Is the patient covered by additional insurance? ☐YES ☐NO

Subscriber's Name _____ Birthdate _____ SS# _____

Relationship to Patient _____ Insurance Company _____

ID# _____ GROUP # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr. Ike B Gorman DPM

all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions

The above named doctor may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services I hereby acknowledge that this office has the option to accrue interest on my account, at the rate of 1.5% per month, if it becomes delinquent

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Ike B Gorman DPM

Name of Doctor or Clinic

for any services burnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or befits for related services.

_____ _____

Patient's Signature Date

_____ _____

Guardian/Guarantor Signature Date

_____ _____

Witness Date

How will you be paying for this visit today? ( ) Visa ( ) MC ( ) Cash ( ) Debit

PODIATRIC MEDICAL HISTORY

Pharmacy: _____ Location: _____ Height: _____ Weight: _____

Family Physician: _____ Last Visit Date: _____

Medications: _____ Surgeries you have had: _____

_____ _____

Patient's Chief Complaint _____

Have you ever seen a podiatrist before? ☐YES ☐NO

If yes, please list: Dr: _____ Complaint: _____

Personal/Family History of Diabetes ☐YES ☐NO

Cigarette or tobacco use ☐YES ☐NO

Years smoked: _____

Allergies: _____

Place a mark on the "Yes" or "No" to indicate if you have had any of the following:

Podiatric Conditions

Ankle Pain	☐YES	☐NO	Numbness in Feet or Legs	☐YES	☐NO	Ingrown Toenails	☐YES	☐NO
Athlete's Foot	☐YES	☐NO	Flat Feet	☐YES	☐NO	Plantar Warts	☐YES	☐NO
Bunions	☐YES	☐NO	Foot or Leg Cramps	☐YES	☐NO	Swelling in Ankles/ Feet	☐YES	☐NO
Corns and Calluses	☐YES	☐NO	Heel Pain	☐YES	☐NO	Tired Feet	☐YES	☐NO

Medical Conditions:

AIDS/HIV	☐YES	☐NO	Epilepsy	☐YES	☐NO	Rash	☐YES	☐NO
Allergies to Anesthetics	☐YES	☐NO	Eye Problems	☐YES	☐NO	Respiratory Problem	☐YES	☐NO
Allergies to Drugs	☐YES	☐NO	Fainting	☐YES	☐NO	Rheumatic Fever	☐YES	☐NO
Anemia	☐YES	☐NO	Foot /Leg Cramps	☐YES	☐NO	Shortness of Breath	☐YES	☐NO
Arthritis	☐YES	☐NO	Gout	☐YES	☐NO	Sinus Problems	☐YES	☐NO
Artificial Heart Valves/ Joints	☐YES	☐NO	Headaches	☐YES	☐NO	Special Diet	☐YES	☐NO
Asthma	☐YES	☐NO	Heart Disease	☐YES	☐NO	Stroke	☐YES	☐NO
Back Problems	☐YES	☐NO	Hemophilia	☐YES	☐NO	Swollen Neck Glands	☐YES	☐NO
Bleeding Disorders	☐YES	☐NO	High Blood Pressure	☐YES	☐NO	Tuberculosis	☐YES	☐NO
Cancer	☐YES	☐NO	Kidney Problems	☐YES	☐NO	Ulcers	☐YES	☐NO
Chemical Dependency	☐YES	☐NO	Liver Disease	☐YES	☐NO	Varicose Veins	☐YES	☐NO
Chest Pain	☐YES	☐NO	Low Blood Pressure	☐YES	☐NO	Venereal Disease	☐YES	☐NO
Chronic Diarrhea	☐YES	☐NO	Neuropathy	☐YES	☐NO	Weight Loss, unexplained	☐YES	☐NO
Circulatory Problems	☐YES	☐NO	Phlebitis	☐YES	☐NO			
Diabetes	☐YES	☐NO	Psychiatric Care	☐YES	☐NO			
Ear Problems	☐YES	☐NO						

I hereby consent/authorize the doctor/dr's assistants/designated replacement to administer/perform such procedures upon me as the doctor deems necessary.

_____ _____

Patient's Signature Date

_____ _____

Guardian's Signature Date

_____ _____

Witness Date