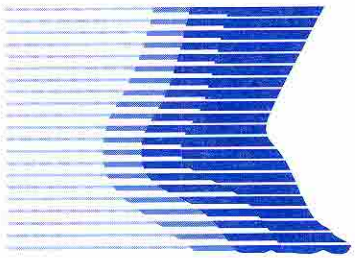

Dr. John Patton

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____ Work Phone _____

Business Address _____

In case of emergency, notify _____ Home Phone _____

Cell Phone _____ Work Phone _____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____ Social Security # _____

Birthdate _____ Relation to Patient _____

Address (if different) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____ Work Phone _____

Business Address _____

Insurance Company _____ Contract # _____ Group # _____ Subscriber # _____

Insurance Phone _____ Address _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Social Security # _____

Birthdate _____ Relationship to Patient _____

Address (if different) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Subscriber Employed by _____ Work Phone _____

Insurance Company _____ Contract # _____ Group # _____ Subscriber # _____

Insurance Phone _____ Address _____

Name of other dependents under this plan _____

Please complete both sides.

Family Medical History

	Diabetes	Heart Disease	Cancer (Type)	Gout	Arthritis	Foot Problems	Other
Father							
Mother							
Brother(s)							
Sister(s)							
Grandparent(s)							

Social History

Check (✓) whether you use any of the following:

☐ Yes ☐ No Caffeine Amount _____ ☐ Yes ☐ No Alcohol Amount _____

☐ Yes ☐ No Tobacco Amount _____ ☐ Yes ☐ No Recreational Drugs Amount _____

Height _____ Weight _____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If "Yes", please describe: _____

_____

Are you currently under physician care? ☐ Yes ☐ No If "Yes", name of physician: _____

WOMEN: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) whether you have had or currently have any of the following:

Aids/HIV		Gout		Skin Rash	
Anemia		Glaucoma		Stomach Problems	
Arthritis		Headaches		Stroke	
Rheumatoid Arthritis		Heart Murmur		Surgical Implant	
Artificial Heart Valves		Heart Disease		Swelling of Legs	
Artificial Joints		Hemophilia Bleeding Problems		Thyroid Disease	
Asthma		Hepatitis		Tonsillitis	
Back Problems		High Blood Pressure		Tuberculosis	
Blood Clot		Kidney Disease		Ulcer	
Cancer (type)		Liver Disease		Varicose Veins	
Cholesterol Problems		Mitral Valve Prolapse		OTHER	
Chest Pain		Psychiatric Care			
Circulatory Problems		Respiratory Disease			
Diabetes		Rheumatic Scarlet Fever			
Epilepsy		Seizures			
Fatigue		Shortness of Breath			

List medications and dosages you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List drug allergies:

_____

_____

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I give permission to John Patton, Ltd. to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremities.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment or co-pay is due in full at time of treatment, unless prior arrangements have been approved.

Dr. John Patton
Disease, Disorders & Surgery of the Foot & Ankle
John. P. Patton, DPM, FACFAS

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a .prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to 'you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All,costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party _____

Printed Name of Patient/Responsible Party _____ Date _____

Witness Signature _____

Printed Name of Witness _____ Date _____

_____ Patient Initials (indicates copy has been received)

1775 Browning Way, Suite 101 • Elko, Nevada 89801 • Phone 775-753-4044 • Fax 775-753-5694

Dr. John Patton
Disease, Disorders & Surgery of the Foot & Ankle
John. P. Patton, DPM, FACFAS

NOTIFICATION AUTHORIZATION

Patients Name _____

Date of Birth _____

I give permission to my provider and/or employees of John Patton LTD to notify me about my healthcare, including, but not limited to, test results, treatment plans, appointments, prescriptions and account information, with the following people or devices.

Initial each applicable category:

_____ Patient Only

_____ Answering Machine

_____ Spouse - Name _____

_____ Parent - Name (s)_____

_____ Other - Name (s) _____

Can we call you at work? Yes_____ No _____
Initial Initial

If so, what phone number _____

_____ _____
Patient/Guardian Signature Date

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