

Patient Information Sheet

Personal Information: (PLEASE PRINT CLEARLY)

Name _____ SS# _____ Birthday _____ Age _____
Address _____ City _____
State _____ Zip Code _____ Home Phone _____ Cell Phone _____
Employer _____ Occupation _____
Address _____ City _____ State _____ Zip _____ Phone _____
Marital Status _____ Sex: Male Female
In an emergency contact _____ Relationship _____ Phone _____
Referred By _____ Physician Patient Insurance Company
 Hospital Phone Book On-Line
Primary Care Physician: _____ Phone: _____
First Name Last Name

Responsible Party: (If patient is a minor)

Name _____ SS# _____ Relationship _____
Address _____ City _____ State _____ Zip _____ Phone _____
Employer _____ Occupation _____

Insurance Information:

We will make a copy of your insurance card for our records. If you do not have your card with you, you will need to provide a copy of your insurance card (front and back) and fax it to us at 303-423-2536 within 24 hours.

We will make a copy of your referral (if required) for our records. If you do not have a referral, please ask the front office staff for additional information before seeing the doctor.

Payment Policy

Your insurance is a contract between you and your insurance company. While we cannot guarantee that your insurance company will pay your claim, we will provide information to them if requested and the above data is accurate and complete

If you do not have insurance, then payment is due in full at the time of service.

Insurance Authorization and Assignment

I hereby authorize Rocky Mountain Foot & Ankle Center to furnish information to insurance carriers regarding my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any CO-PAYMENTS, DEDUCTIBLES OR BALANCES not covered by my insurance. I authorize use of this form and all my insurance submissions, and I permit a copy of this authorization to be used in place of the original. By signing this form I am consenting to treatment by the doctor in this office and agree to the terms indicated above.

Acknowledgement of Receipt of Privacy Practices

I have reviewed a copy of Rocky Mountain Foot & Ankle's Notice of Privacy Practices with an effective date of April 14, 2003.

Signature _____ Today's Date _____

Parent's printed name and signature if patient is a minor.

First Visit Information**PLEASE PRINT CLEARLY**

Name: _____

Why are we seeing you today? _____

How long has this been a problem? _____ Which foot: right left both

Shoe size: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Phone: _____

First Name

Last Name

Medical / Family History

Please circle to indicate "Y" (yes) or "N" (no).

<u>Self</u>	<u>Family</u>		<u>Self</u>	<u>Family</u>	
<u>Y</u>	<u>N</u>	Anemia?	<u>Y</u>	<u>N</u>	Liver Problems?
<u>Y</u>	<u>N</u>	Arthritis?	<u>Y</u>	<u>N</u>	Lung disease? Circle type COPD
<u>Y</u>	<u>N</u>	Asthma?			Emphysema
<u>Y</u>	<u>N</u>	Cancer? What type, when? _____	<u>Y</u>	<u>N</u>	Neurologic disorders? Type _____
<u>Y</u>	<u>N</u>	Circulation problems?	<u>Y</u>	<u>N</u>	Osteoporosis?
<u>Y</u>	<u>N</u>	Diabetes? Date of diagnosis _____	<u>Y</u>	<u>N</u>	Phlebitis / Blood clots?
<u>Y</u>	<u>N</u>	Excessive bleeding?	<u>Y</u>	<u>N</u>	Psychiatric disorders? Type _____
<u>Y</u>	<u>N</u>	HIV or AIDS?	<u>Y</u>	<u>N</u>	Rheumatic fever / murmur?
<u>Y</u>	<u>N</u>	Healing problems?	<u>Y</u>	<u>N</u>	Stomach ulcers / peptic ulcers?
<u>Y</u>	<u>N</u>	Heart attack? Date _____	<u>Y</u>	<u>N</u>	Stroke?
<u>Y</u>	<u>N</u>	Heart failure?	<u>Y</u>	<u>N</u>	Thyroid disease?
<u>Y</u>	<u>N</u>	Hepatitis? A, B, C or other _____	<u>Y</u>	<u>N</u>	Do you have any metal implants, plates, pins or screws?
<u>Y</u>	<u>N</u>	High Blood Pressure?	<u>Y</u>	<u>N</u>	Other, describe _____
<u>Y</u>	<u>N</u>	Kidney problems? Dialysis? _____			

Please answer the following questions:

List all allergies to medications, adhesive tape, or latex:

Please list any medications you take and dosage:

Please list surgeries and hospitalizations:

Do you smoke? yes no Packs per day _____

Do you drink alcohol? yes no Amount per day _____

Do you drink caffeinated beverages? Amount per day _____

Any recreational drug use? _____

Please list any other physicians who have treated your feet, and when:

(Women) Are you pregnant? yes no Are you breastfeeding? yes no