MONTANA FOOT AND ANKLE

Dr Thomas Wright

PATIENT REGISTRATION

Today's Date ____/____/___

PATIENT INFORMATION

Patient's Last Name	First	Middle	Date of Birth	Sex ☐ Male ☐ Female
Perferred Name	Marital Status ☐ Single ☐ Married ☐ Div ☐ Sep ☐ Wid		Social Security Number	Home Phone
Mailing Address	City, State		Zip Code	Cell Phone
Email	Pharmacy		Primary Care	

FINACIAL RESPONISBILITY

Name		Date of Birth	Relationship	Social Security Number
Mailing Address		Employer		Phone number
City	State	Zip	Email	

INSURANCE INFORMATION (PLEASE GIVE CARD AND PHOTO ID TO RECEPTIONIST)

Primary insurance	Subscriber Name	Date of Birth
ID#	Group #	Co-Payment
Secondary insurance	Subscriber Name	Date of Birth
ID#	Group #	

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship	Home Phone	Work Phone

REFERRAL

How did you learn about us?

☐ Google ☐ Facebook ☐ Dr Office_____ ☐ Friend_____

Certification

The above information is true to the best of my knowldege. I certify that I have insurance with the insurance company(ies) disclosed and assigned directly to **Montana Foot and Ankle** , all insurance benefit, if any otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. **Montana Foot and Ankle** may use my health care information and may disclose such information to the insurance company(ies) and their agents for services and determining insurance benefits or the benefits payable for related services.

PATIENT/GUARDIAN SIGNATURE **DATE**

PRINT NAME **RELATIONSHIP**

MONTANA FOOT AND ANKLE

Dr Thomas Wright

COMPREHENSIVE HEALTH REVIEW

Patient Name _____ Date of Birth ___ /___ /____Todays Date ____ /____/_____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN TODAY?

What is your specific foot/ankle problem? _____

_____

When did the problem begin?_____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

What aggravates the problem?_____

What improves the problem?_____

My foot/ankle problem limits my activities ☐ Yes ☐ No

Which foot/ankle is involved? ☐ Right ☐ Left ☐ Both

First visit to a doctor for this problem? ☐ Yes ☐ No

Have you had a similar problem in the past? ☐ Yes ☐ No

How was the problem onset? ☐ Sudden ☐ Gradual

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ Active

Is the problem painful? ☐ Yes ☐ No If so, rate your current pain (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain:_____

_____

Describle previous treatments: _____

Is this from an injury? ☐ Yes ☐ No If so, is it work related? ☐ Yes ☐ No Auto accident? ☐ Yes ☐ No

Occupation:_____ Sports/Activities: _____

PAST MEDICAL HISTORY

☐ Diabetes Type 1 2 Duration ____years Last Blood Sugar ____ HbA1c ___

☐ Acid Reflux

☐ Anemia

☐ Anesthesia Complicatons

☐ Arthritis ☐ Osteo/ ☐ Rheum

☐ Asthma

☐ Back Problems/Sciatica

☐ Blood Clot/DVT

☐ Cancer _____

☐ Cellulitis/ Skin infection ☐ MRSA

☐ Circulation Problems

☐ Demenia/Alzheimer's

☐ Excessive/Easy Bleeding

☐ Fibromyalgia

☐ Foot/Leg Ulcers

☐ Gout

☐ Healing Problems/Keloids

☐ Heart Disease/Heart Attack

☐ High Blood Pressure ☐ Low BP?

☐ High Cholesterol

☐ Hormone Therapy

☐ Immune Disorder/HIV

☐ Kidney Disease ☐ Dialysis

☐ Other problems not listed

☐ Liver Disease ☐ Hepatitis

☐ Leg Cramps/Leg Pain at Rest

☐ Lung Condition:_____

☐ Mitral Valve Prolapse/Murmur

☐ Multiple Sclerosis

☐ Nervous Disorder/Depression

☐ Neuropathy

☐ Osteomyelitis/Bone Infection

☐ Parkinson's Disease

☐ Previous Addiction to:_____

☐ Pulmonary Embolism

☐ Rashes/Skin Condition

☐ Raynauds Disorder/Epilepsy

☐ Seizure Disorder

☐ Sickle Cell Disease/Trait

☐ Sleep Apnea

☐ Stomach Ulcers

☐ Stroke ☐ RT ☐ LT

☐ Thyroid Condition

☐ Varicose Veins

Woman ☐ Pregnant ☐ Nursing

ALLERGIES

☐ None ☐ Latex

☐ Adhesive/Tape ☐ Local Anesthetics

☐ Asprin ☐ Penicillin

☐ Codeine ☐ Seafood/Shellfish

☐ Cortisone ☐ Sulfa Drugs

☐ Iodine ☐ _____

PAST SURGERIES

☐ Foot/Ankle Surgery:_____

☐ Joint Replacement:_____

☐ Open Heart/Bypass Surgery

☐ Hysterectomy

☐ Stent Placement: ☐ Heart ☐ Leg

☐ Cosmetic Surgery:_____

☐ Appendix ☐ Gallbladder

☐ Tonsils/Addnoids ☐ Leg Bypass

☐ Carotid Surgery ☐ Thyroid

☐ Vein Surgery

☐ Hernia repair

☐ Back Surgery

☐ Other_____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medications Dosage

SOCIAL HISTORY

Alcohol ☐ Yes How often?_____ Recreation Drugs? ☐ Yes ☐ No

Tobacco ☐ Never ☐ Quit, ____ years ago ☐ Currently using? Packs per day ____

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Recent Weight Change
- ☐ Fever/Chills
- ☐ Nausea or Vomiting
- ☐ Fatigue

EYES
- ☐ Eye Disease/injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred or Double Vision
- ☐ Glaucoma

EAR/NOSE/MOUTH/THROAT
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Sore Throat/Voice Change
- ☐ Sinus Problems
- ☐ Difficulty Swallowing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpations
- ☐ Arrhythmia
- ☐ Leg pain when walking
- ☐ Swelling of Hands/Feet

MUSCULOSKELETAL
- ☐ Muscle Pain or Cramps
- ☐ Joint Pain
- ☐ Stiffness/Swelling Joints
- ☐ Low Back Pain
- ☐ Trouble Walking

GASTROINTESTINAL
- ☐ Indigestion/Hearburn
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Stomach Pains

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Chronic/Frequent Cough
- ☐ Wheezing

GUNITOURINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Blood in Urine

INTEGUMENTARY
- ☐ Rash or Itching
- ☐ Dry Skin
- ☐ Change in Hair/Nails

HEMATOLOGICAL
- ☐ Bruise Easily
- ☐ Slow to Heal

ENDOCRINE
- ☐ Hormonal Problem
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Too Hot/Too Cold

NEUROLOGICAL
- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Numbness/Tingling
- ☐ Dizzy Spells
- ☐ Paralysis/Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Insomnia
- ☐ Confuison/Memory Loss

STATS

Age_____ Height_____ Weight_____ Shoe Size_____

The information that I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive bettr care.

PATIENT/GUARDIAN SIGNATURE DATE

MONTANA
FOOT AND ANKLE

Thomas Wright, DPM

1125 West Kagy suite 101
Bozeman, MT 59715
Phon 406-586-5318
Fax 406-586-1635

OFFICE POLICY

1. At your initial visit, we will try to verify your benefits. If we are unable to verify your benefits, payment in full will be due at time of service. You will be refunded once we receive insurance payment. We accept cash, check, debit, and all major credit cards.

2. It is your responsibility to provide accurate insurance information and to present insurance ID card and picture identification at the time of your visit.

3. Surgical Patients are required to leave a $500 deposit prior to surgery or leave a credit card number on file with us. The remaining balance is due within 30 days of insurance settlement.

4. It is your responsibility to understand your benefit plan. Not all services provided by our office are covered by every plan. Our office will do our best to inform you of non-covered services. Any service determined not covered by your plan will be your responsibility. The undersigned agrees they are the responsible party for payment.

5. Patient balances are billed monthly.

6. It is your responsibility to ensure that our clinic is in your network.

7. Patient balances are billed monthly.

8. Failure to show to your appointment, without contacting our office, will result in a $70 fee.

9. Your account will be considered in default for any balance unpaid after 60 days. If your account goes into default: You understand and agree that in addition to the principal amount due, you are responsible for all costs and fees of account collections including, but not limited to, attorney fees, collection agency fees that may be up to 50% of the amount owed, court costs, debit/credit card transaction fees, and interest at the highest amount allowed by law. These costs and fees are actual costs that are incurred, and these costs and fees result in a monetary loss due to consumer's failure to pay.

10. The proper venue for any action filed to enforce the terms of his agreement shall be Gallatin County, Montana

I have read and fully understand Montana Foot and Ankle Policy. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a patient of or have an outstanding balance with Montana Foot and Ankle Clinic. I have read this complete page and agree to all of its contents.

_____ _____

Name of Individual/Legal Guardian (Print) Signature of Individual/Legal Guardian Date

_____

Name of Patient

MONTANA
FOOT AND ANKLE

Thomas Wright, DPM

1125 West Kagy suite 101
Bozeman, MT 59715
Phon 406-586-5318
Fax 406-586-1635

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Montana Foot and Ankle Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the notice.

Patient Initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

I give express consent for Montana Foot and Ankle and its collection agency to contact me via cell/home phone, email and text and to leave a message with family members, voicemail or answering machine regarding the following: (1) Confirm or Change an Appointment, (2) Results of tests ordered by the physician, (3) Any Pertinent information that may be relative to my care, (4) Any attempt to collect on outstanding balances.

Patient Initials: _____

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by Montana Foot and Ankle , encompassing routine care, diagnostic procedures, examinations, and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-ray, ultrasound, photographs and administration for medications and injections prescribed by Montana Foot and Ankle and performed by its doctors and staff. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assigned directly to Montana Foot and Ankle and its doctors, and insurance benefits, if any otherwise payable to me for service(s) rendered.

Montana Foot and Ankle my use my health care information and may disclose such information to the disclosed 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.

Patient Initials: _____

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a patient of Montana Foot and Ankle. I have read this complete page and agree to all of its contents.

_____ _____

Name of Individual/Legal Guardian (Print) Signature of Individual/Legal Guardian Date

_____

Name of Patient