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	

FINANCIAL RESPONSIBILITY

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_____________________________ ☐ Other ________________

Certification

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assigned directly to Bozeman Podiatric Clinic, DBA 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. Bozeman Podiatric Clinic, DBA 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**

Patient Health History

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:____

____

Describe 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 Complications

☐ Arthritis ☐ Osteo/ ☐ Rheum

☐ Asthma

☐ Back Problems/Sciatica

☐ Blood Clot/DVT

☐ Cancer __________________________

☐ Cellulitis/ Skin infection ☐ MRSA

☐ Circulation Problems

☐ Dementia/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:____________

☐ Rashes/Skin Condition

☐ Raynaud's Disorder/Chilblains

☐ Seizure Disorder/Epilepsy

☐ 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

☐ Aspirin ☐ 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/Adenoids ☐ 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 ☐ No ☐ Yes How often?_______________ Recreation Drugs? ☐ No ☐ Yes

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/Heartburn
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Stomach Pains

RESPIRATORY

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

URINARY

- ☐ 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
- ☐ Confusion/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 better care.

______________________________ ______________________________

PATIENT/GUARDIAN SIGNATURE **DATE**

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Bozeman Podiatric Clinic, DBA Montana Foot and Ankle, Notice of Privacy Practices and that I have read or have the opportunity to read and understand the notice.

Patient Initials: ________

AUTHORIZATION REGARDING PRIVACY POLICY

I give express consent for Bozeman Podiatric Clinic , DBA 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: to confirm or change an appointment, results of tests ordered by the physician, any pertinent information that may be relative to my care, and any attempt to collect on outstanding balances.

Patient Initials: ________

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by Bozeman Podiatric Clinic, DBA 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 as prescribed by Bozeman Podiatric Clinic, DBA 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 Bozeman Podiatric Clinic, DBA Montana Foot and Ankle, and its doctors, and insurance benefits, if any otherwise payable to me for service(s) rendered. Bozeman Podiatric Clinic, DBA Montana Foot and Ankle, may 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 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 for as long as I am a patient of Bozeman Podiatric Clinic, DBA 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

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, care credit, and all major credit cards.

2. It is your responsibility to provide accurate insurance information and to present insurance ID card(s) 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. It is your responsibility to ensure that our clinic is in your network.

6. Patient balances are billed monthly.

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

8. If you are more than 10 minutes late for your scheduled appointment, we reserve the right to reschedule you.

9. Your account will be considered in default for any balance unpaid after 60 days. I understand that in the event any unpaid balance is placed for collections with any third- party collection agency, a fee of **50%** of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by Montana Foot and Ankle to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

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

I have read and fully understand the Bozeman Podiatric, DBA Montana Foot and Ankle, office policy. This authorization is valid as of the date I have signed below and will remain in effect for as long as I am a patient of or have an outstanding balance with Bozeman Podiatric Clinic, DBA 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