Patient information

Patient Full Name: ______________________________________ Date: ____________________________

Middle Initial

DOB: ___________________________ Sex: M / F Social Security Number: ______-_____-_________

Race: *(please circle)* American Indian/Alaska Native Asian Black/African American White Other race Decline

Ethnicity: *(please circle)* Hispanic/Latino NOT Hispanic or Latino Decline

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated [ ] Partnered for ________ years

Address:____

City:_________________ State:__________________ Zip:_________________

Home Phone: ___________________ Work: _________________ Cell: ____________________________

Email address* (we will never share your email address with anyone): ______________________________________

*Email will not be used for any personal medical identifying information.

Preferred method of communication *(please circle):* Home phone Work phone Cell phone email

Employment status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Disabled [ ] Student

Employer: ______________________________ Occupation: ______________________________

Spouse name: ____

Spouse's employer: _______________________________ DOB: ___________ SSN: ________________

Emergency contact information

Emergency contact name: ____

Contact phone # ( ) ____________________________________ Relationship: __________________

Billing & Insurance Information

Primary Insurance Name: ____

Policy # ____ Group # ______________________________

Policy holder name/Guarantor: _____________________________ SSN _______________ DOB _______

Address: ____

City State Zip

Secondary Insurance Name: ____

Policy # ____ Group # ______________________________

Policy holder name/Guarantor: _____________________________ SSN _______________ DOB _______

Address: ____

City State Zip

Pharmacy Information

Pharmacy Name: ____ Phone # ________________________

Pharmacy Address: ____

Referral Information *Whom may we thank for referring you to our office?*

Name: _______________________________________ Address: ______________________________

Is this person your: *(please circle)* PCP Other specialist Family Member Friend Previous patient Other

Other referral sources *(please circle)* Internet search (Google/other) Yellow pages/Dexonline Insurance Website Mailer

Patient full name: ________________ DOB: ___________________________
Name of Primary Care Physician: ____________________ Date of last visit: ______________________
Address: ____ Phone: (___)____________
City State Zip
Are you now, or have you been under any other doctor's care for any reason in the last two years? Yes No
If yes, please explain: ____

PODIATRIC HISTORY

Have you ever been to a Podiatrist before? Yes No
What is your main foot or ankle complaint for which you are seeking treatment? _________________________

When did it begin? ________________________
Have you received treatment for this condition? Yes No
If so, what has been done? _______________________

Does this problem interfere with your activities? Yes No
Please explain: _________________________________

Circle the degree of pain you are experiencing

Minimal ☺ 1 2 3 4 5 6 7 8 9 10 ☹
What is your shoe size? _________________
Narrow Medium Wide

Have you ever experienced any of the following?
Please check all that apply:

____ Ankle Instability
____Arthritis
____Back pain
____Blisters
____Bone spurs
____Bunions
____Burning feet
____Corns/calluses
____Flat feet
____Foot infection
____Fracture
____Fungal infection
____Tendonitis
____Tired feet
____Ulcers/wounds
____Warts
____Hip pain
____Ingrown toenails
____In/out toe walking
____Knee pain
____Limb length inequal
____Neuromas
____Numbness/tingling
____Plantar fasciitis
____Shin splints
____Sprains
____Sweating/odor
____Fungal toenails
____Gout
____Hammertoes
_____Heel pain

MEDICAL HISTORY

Surgeries/hospitalizations

Surgery/Hosp	Date

MEDICATIONS

You can provide a list of your medications or list below

Name	Strength/mg	Take how often?

Are you currently taking blood thinners? Yes No

FAMILY HISTORY

Please check all that apply	Relationship to you:
____Heart disease	
____Diabetes	
____Cancer	
____Other: __________	

SOCIAL HISTORY

Do you currently use cigarettes or tobacco? Yes No
#years smoked _____ How many packs/day? ____
If quit, what year? _____________
Alcohol use? Yes No
If yes, quantity ________ per day ______per week

Do you participate in any exercise or physical activity on a regular basis? Yes No
If so, what type/how often:______________________

Patient full name: _______________ DOB: ________________________

What is your current height? _______________________ Current weight: _________________

Have you been treated for any of the following conditions? Please check all that apply:

__Acid reflux
__Alcoholism
__Allergies
__Alzheimer's disease
__Anemia
__Arthritis
__Asthma
__Back problems
__Bleeding disorders
__Blood clots/DVT/PE
__Cancer
__Circulatory problems
__Congestive heart failure/CHF
__Depression
__Diabetes
__Drug or chemical dependency
__Ear problems
__Eye problems
__Fibromyalgia
__Headaches
__Heart condition
__Hepatitis
__High cholesterol
__HIV/AIDS

__High blood pressure
__Low blood pressure
__Hyperthyroidism
__Hypothyroidism
__Kidney/bladder problems
__Liver disease
__Medical implants
__Nerve system disorder
__Osteoporosis/osteopenia
__Peripheral vascular/arterial disease
__Parkinson's disease
__Psychiatric care
__Respiratory disease
__Rheumatic fever
__Seizure disorders/epilepsy
__Sinus problems
__Sleep apnea
__Stomach ulcers
__Stroke
__Tuberculosis/TB
__Varicose veins
__Vertigo
__ Other: ______________

Infections:

__MRSA
__Hepatitis B
__Hepatitis C

Allergies Yes / No

If yes, please check all that apply

Adhesive Tape		Metal/jewelry	
Anticoagulants		Lidocaine/novocaine	
Anti-inflammatories		Peanuts	
Aspirin		Penicillin	
Codeine		Seafood	
Cortisone		Sulfa	
Iodine		Tylenol	
Latex		Motrin/ibuprofen	
Other: ______________________________________			

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Denver Foot and Ankle Clinic, PC and any qualified staff to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

____

Patient signature Date

Financial Policy

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have developed this payment policy to assist you in understanding our financial practices. Please read it carefully and sign in the space provided below.

Insurance

We participate with most insurance plans. If you do not have insurance or we do not participate in your insurance plan, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility but we will help explain your podiatric benefits so you can understand them.

We will keep a copy of your insurance card in your record, but you must notify us immediately if there has been any change. If you fail to inform us of updated insurance information, the balance on unpaid claims will become your responsibility. The Co-Pay is due at each visit. Co-Insurance, and deductibles are your responsibility and we may ask for pre-payment.

I certify that I have insurance with ___________________________________
Name of insurance company

and assign directly to Denver Foot and Ankle Clinic, PC 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.
Denver Foot and Ankle Clinic may use my health care information and 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. This consent will end when my current treatment plan is completed or one year from the date signed below.
I request that payment authorized Medicare/Medicaid/Private insurance benefits, and, if applicable, Medigap benefits be made either to me or on my behalf Denver Foot and Ankle Clinic for any services rendered to me by that provider.
To the extent of the law, I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Non-covered Services

Please be aware that some of the services you receive may be non-covered by your insurance carrier. These services must be paid for at the time of visit.

Claims Submission

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request promptly.

Payment

For your convenience, we accept cash, checks, VISA, MasterCard, and Discover. We reserve the right to refer your account to a collection agency if your account is over 90 days past due. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the delinquent account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all pat due accounts.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read and understand the financial policy and agree to abide by its guidelines.

Signature: _______________________ Date: __________________

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main office number **303.761.5454**

Signature below is acknowledgement that you have received and understand this notice of our privacy practices.

Print name:____

Signature:____Date:___________

Email/Text Messaging Authorization

Due to the high volume of calls to confirm appointments, we are asking patients to assist our office by accepting a text message or email to confirm all future appointments. In the event of inability to receive or send a text message or e-mail, a phone confirmation will be given.

Please check one of the below options:

___I have read and understand the above information and authorize text messaging communication with Denver Foot and Ankle Clinic.

__I have read and understand the above information and authorize e-mail communication with Denver Foot and Ankle Clinic.

__I DO NOT authorize e-mail or text message communication from Denver Foot and Ankle Clinic.

Text: ___________________ Cell phone carrier:_______________ E-mail: __________________________

I understand that I am responsible for any fees from my cell phone provider for receiving text messages. I understand that Denver Foot and Ankle Clinic with never sell or give this information to anyone. I understand that I may withdraw my authorization at any time, and that I have a right to receive a copy of this form.

Our office cannot guarantee the security of any information sent or received via e-mail or text messaging. For this reason and others, our office aims to keep outbound e-mails brief and pertaining to practical (not clinical) matters. Please note that our practitioners do not conduct treatment via e-mail or text and cannot respond to urgent matter received by email or text.

I authorize Denver Foot and Ankle Clinic to use the above information for the following family members:

Print name: _________________________________

Signature or patient or guardian: _______________________________________ Date: ________________