Cheyenne Foot & Ankle

Patient Registration and Health History

Patient Information Date: _____________
Patient ____
Address ____
City ____________________ State ____________________________ Zip _________________
Primary Phone _____________________________ Cell Phone ______________________
Emergency Contact: Name ______________ Relationship__________ Phone______________
Email Address ____
Date of Birth _____________ Age _____ Sex: Male or Female
Whom may we thank for referring you? ____
Single ____ Married _____ Divorced _____Widowed ____ Spouse Name_______________

Basic Health Information
Primary Care Provider (Dr.) ____________________________Date Last Seen _____________
Pharmacy Used ____________________________________ Location _________________
*Primary Language Spoken ____
*Please select your race American Indian / Alaskan Native / Asian / African American
Caucasian / Pacific Islander / Other / Declined

*Please select your Ethnicity Hispanic / Non-Hispanic / Declined

*Requirement of our Government's Health Information Technology for Economic and Clinical Health Act (HITECH)

Employment

Employed by ____
Business Address ____
Phone # _________________
Occupation __________________

Patient name _______________________________

Consent to Treat

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third party payer can verify that services billed were actually provided
And a tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practice that provides a more complete description of information uses and disclosures. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organizations is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

____________________________________ __________________________
Patient/ Parent or Guardian Signature Date

Colorado Prescription Drug Monitoring Program

IF YOU RECEIVE A PRESCRIPTION FOR "CONTROLLED" (SCHEDULE II THROUGH V) DRUG, YOUR IDENTIFYING PRESCRIPTION INFORMATION WILL BE ENTERED INTO COLORADO'S ELECTRONIC PRESCRIPTION DRUG MONITORING DATABASE (PDMP) WHEN THIS DRUG IS DISPENSED TO YOU. YOUR PRESCRIPTION INFORMATION IN THE DATABASE IS A PROTECTED HEALTH RECORD AND CANNOT BE ACCESSED BY NON-CAREGIVERS EXECPT AS PART ON AN AUTHORIZED INVESTIGATION.

YOU HAVE A RIGHT TO ACCESS YOUR INFORMATION IN THE PDMP THROUGH THE COLORADO BOARD OF PHARMACY. YOU MAY SEEK CORRECTIONS TO THE INFORMATION AS YOU WOULD YOUR OTHER MEDICAL RECORDS.

I request the following restrictions to the use or disclosure of my health information:

____ Accept ____ Declined

____________________________________ ________________________
Patient/ Parent or Guardian Signature Date

Patient name ____________________________________

Podiatric History (Are you currently or have you been treated in the past for any of the following conditions? Circle)

Ankle Pain	Athlete's Foot	Bunions	Corns & Calluses	Cramps or Numbness
Flat Feet	Foot or Leg Cramps	Heel Pain	Ingrown Toenails	Plantar Warts

What is the reason for your visit today? ____

____

Have you been to a Podiatrist before? If yes, who ____________________ Last seen ________________

How would you describe your pain? Sharp aching shooting burning dull other

Where exactly is your pain? (i.e. – between toes, great toe, bottom of heel, middle of heel, back of heel)

Which foot or ankle? Left Right

Pain Level	0	1	2	3	4	5	6	7	8	9	10
	None				moderate				severe		

How long have you had this pain? # _____ days ____ weeks _____ months ______ years

Has the pain increased, decreased or stayed the same?

What appears to aggravate your pain?

What have you tried to help relieve the pain?

What has helped to relieve the pain?

Medical History

Please check if you have or have had any or the following:

___ Heart trouble
___ Kidney trouble
___ High blood pressure
___ Tuberculosis
___ Stomach ulcers
___ Broken bones in foot or leg
___ Asthma- Emphysema
___ Gout
___ Have AIDS or ore HIV positive
___ Pancreatitis
___ Numbness in feet or legs
___ High Cholesterol

___ Anemia
___ Blood disease
___ Circulation disease
___ Hardening or arteries
___Reynaud's disease
___ Varicose veins
___ Arthritis (Osteo or Rheumatoid)
___ Cancer
___ Epilepsy
___ Liver trouble
___ Diabetes
___ Thyroid Problems

List your reaction if you are allergic or sensitive to:

___ Penicillin
___ Erythromycin
___Sulfa
___ Novocain
___ Codeine
___ Anesthetics
___ Adhesive tape
___ Foods
___ Materials
___ Other (please describe)
____
___ None of above

___ None of above ___ Other______________________

Height______ Weight_______ Shoe Size______

Patient name ___________________________________

Surgeries & Hospitalizations (List all procedures, locations and any complications)

____
____
____

Medications (List all prescription medications that you are currently on. List dosage & frequency.)

____
____
____
____
____
____
____
____
____
____

Social History

Smoking status:	___ Never	___ Current Smoker		___ Former Smoker		___ Social Smoker	
Smoking Amount:	½ pack/day	1 pack/day		2 pack/day		3 pack/day	How long? ____
Do you drink alcohol?	___ Yes	___No	___Rare	___Occasional	___Social	___Daily	___Former
Drinking Amount:	1-2/day	3-4/day	5-6/day	>7/day	1-2/week	3-4/week	5-6/week

Do you use recreational drugs? ___Yes ___No How often?____________

Do you exercise routinely? ___Yes ___No What activities?______________________________

Family History (Do you have any family member being treated for the following? Who and what for?)

		Mother	Father	Sibling
Anemia	___Yes	_______	______	______
Arthritis	___Yes	_______	______	______
Asthma	___Yes	_______	______	______
Cancer	___Yes	_______	______	______
Diabetes	___Yes	_______	______	______
Heart Disease	___Yes	_______	______	______
High Cholesterol	___Yes	_______	______	______
Hypertension	___Yes	_______	______	______
Kidney Disease	___Yes	_______	______	______
Neurologic	___Yes	_______	______	______
Stroke/TIA	___Yes	_______	______	______
Thyroid Disease	___Yes	_______	______	______
Vascular Disease	___Yes	_______	______	______

Patient name ____________________________________

FINANICAL POLICY AND PATIENT AGREEMENT

1. If you are covered by an insurance plan which we maintain a contract, we will bill your insurance company for the services rendered. If your insurance has not paid us after 90 days, or you have not responded to your insurance on requested information, you will become responsible for payment in full. It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
2. At the **time of your visit** you will be responsible for payment of your co-pay, any outstanding patient balance and any dispense supplies not covered by your insurance. Not all services provided in the office are a covered benefit under all insurance plans.
3. If your plan requires a referral and you do not have one, **You will be asked to pay for your visit in full or we will not be able to see you and your appointment will be rescheduled.** It is the sole responsibility of the patient to know your insurance plan and benefits, and to supply this office with a correct and current insurance card.
4. After your insurance plan has paid, please remember any remaining balance is due in full upon notice. Our office does not offer payment plans without prior arrangements with management. Any unpaid balances older than 60 days may be subject to account maintenance and finance charges of 35.00 per month. Returned checks will result in a $30.00 service charge and payment of all fees incurred resulting from the returned check. If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.
5. As a courtesy we do make confirmation calls. At times this may not be possible. It remains the responsibility of the patient to keep all scheduled appointments. Please notify us at least 24 hours in advance if you need to cancel or re-schedule your regular appointment (4 days for surgery). There will be a $50 charge for regular appointments and a $250 charge for surgical appointment in the event you do not show up, cancel or change your appointment without 24 hours notice.
6. If X-rays are taken on your visit, they WILL NOT be released for our office as they become a permanent part of your patient chart. If your need them for another Doctor's appointment in the future, we charge a $25 fee, refundable when the films a returned.
7. We do not enter into disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in case where we have an agreement or we are a participating provider.
8. We do offer a quick pay discount to all cash patients who pay for their visits in full at the time of service. This is only available when your insurance is not billed and does not apple to custom orthotics.

I hereby assign all medical and surgical benefits, to include major benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Patient/Responsible Party Signature: ______________________________________

Relationship to Patient: ______________________________________

Date: ________________

Patient name ___________________________________

Phone Message Consent

Your physician or other staff members may need to contact you. Please fill out the information below.

Name: ____

Primary Phone: ____

Alternate Phone: ____

In an effort to protect your privacy, we have develops a policy regarding leaving medical information.

We will not leave messages with anyone except the patient or legal guardian
We will not leave information on an answering machine
We will not leave massages on a voice mail

UNLESS WE HAVE WRITTEN PERMISSION TO DO SO

Please read below and consider carefully whom you want to have access to your medical information.

I,______________ give Cheyenne Foot & Ankle permission to leave phone messages regarding my medical care at the following numbers. My medical care may be discussed with the person(s) list below.

My cell voicemail _____ Initial
My home answering machine _____ Initial
My office/work voicemail _____ Initial

Spouse (Name)____________ _____ Initial

Other (names) ___________ _____ Initial

___________ _____ Initial

___________ _____Initial

Signature _____________________________ Date __________

****PLEASE INDICATE WHICH # IS BEST TO REACH YOU DURING OUR OFFICE HOURS****

Patient name _________________________________