Bozeman Foot and Ankle Clinic, P.C.
COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____

HISTORY OF PRESENT ILLNESS/ WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

What aggravates the problem? _____

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 ☐ With Activity

What improves the problem? _____

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: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping

☐ Burning ☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other: _____

Describe previous treatments: _____

Have any tests been done? ☐ X-Rays ☐ CT Scan ☐ MRI ☐ Labs ☐ None Where: _____

Is this from an injury? ☐ Yes ☐ No If so, Is it work related? ☐ No ☐ Yes If so, how: _____

MEDICATIONS (INCLUDE RX MEDS, OTC MEDS, AND VITAMINS)

Medication	*Dosage*	*Medication*	*Dosage*

Preferred Pharmacy: _____ **City**: _____

Primary Care Physician: _____

ALLERGIES & REACTIONS

☐ None
☐ Adhesives / Tape
☐ Aspirin
☐ Codeine
☐ Cortisone
☐ Iodine
☐ Latex
☐ Local Anesthetics
☐ Penicillin
☐ Seafood / Shellfish
☐ Sulfa Drugs
☐ Other _____

_____

PAST MEDICAL HISTORY

If yes, check box. If no, leave blank.

☐ Diabetes Type 1 or 2 Duration: _____ Years, Last Blood Sugar _____mg/dl 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 Ulcer
☐ Gout
☐ Healing Problems / Keloids
☐ Heart Disease / Heart Attack
☐ High Blood Pressure ☐ Low BP?
☐ High Cholesterol
☐ Hormone Therapy
☐ Immune Disorder / HIV
☐ Kidney Disease (☐ Dialysis)
☐ 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
☐ Raynaud's Disease / Phenomenon
☐ Seizure Disorder / Epilepsy
☐ Sickle Cell Disease / Trait
☐ Sleep Apnea (☐ on CPAP?)
☐ Stomach Ulcers
☐ Stroke ☐ RT ☐ LT (Year ___)
☐ Thyroid Condition (☐ HI ☐ LO)
☐ Varicose Veins
☐ Women- are you pregnant or breast feeding?

Continued on Back

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY (Circle Relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

☐ Cancer	M F S B GP
☐ Diabetes	M F S B GP
☐ Gout	M F S B GP
☐ Heart Disease	M F S B GP
☐ High Blood Pressure	M F S B GP
☐ Arthritis	M F S B GP
☐ Foot Problems	M F S B GP
☐ Other: _____	M F S B GP

PAST SURGERIES

☐ Foot/Ankle Surgery: ☐ RT / ☐ LT _____
☐ Joint Replacement: ☐ RT / ☐ LT _____
☐ Open Heart / Bypass Surgery / Pacemaker Placement
☐ Stent Placement: Heart / Leg
☐ Cosmetic Surgery: _____
☐ Appendix ☐ Gallbladder ☐ Tonsils
☐ Leg Bypass ☐ Open Fracture Repair
☐ Carotid Surgery ☐ Vein Surgery
☐ Hernia Repair ☐ Thyroid ☐ Back Surgery
☐ Other: _____

SOCIAL HISTORY

Occupation: _____
☐ I Drink Alcoholic Beverages how much / often: _____
☐ I Use or Have Used Tobacco Products Type: _____
Packs / Day _____ Years _____ When Stopped?: _____
☐ I Use or Have Used Illicit Drugs? Type: _____
I live with: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other

I Stand _____ % of my Day
I Exercise Each Week: ☐ 0 days ☐ 1-2 Days ☐ 3+Days
List Sports/Activities: _____
_____
My foot/ankle problem limits my activities? ☐ Yes ☐ No
I am: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Widowed

STATS

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

REVIEW OF SYSTEMS *Symptoms you are currently experiencing*

CONSTITUTIONAL
☐ Recent Weight Change
☐ Gain ☐ Loss
☐ Fatigue
☐ Fever / Chills

NEUROLOGICAL
☐ Dizzy Spells / Fainting
☐ Numbness
☐ Tingling
☐ Seizures
☐ Weakness
☐ Paralysis / Tremors

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

CARDIOVASCULAR
☐ Chest Pain
☐ Palpitations
☐ Arrhythmia / Irregular Heart Beat
☐ Leg Pain when Walking
☐ Swelling of Hands / Feet

EARS/NOSE/MOUTH/THROAT
☐ Hearing Loss
☐ Ringing in Ears
☐ Nose Bleeds
☐ Sore Throat / Voice Changes
☐ Sinus Problems
☐ Difficulty Swallowing

ENDOCRINE
☐ Hormonal Problems
☐ Excessive Thirst
☐ Excessive Sweating
☐ Too Hot / Too Cold

EYES
☐ Vision Changes
☐ Cataracts
☐ Blurred or Double Vision
☐ Glaucoma
☐ Blindness

GASTROINTESTINAL
☐ Indigestion / Heartburn
☐ Diarrhea
☐ Nausea or Vomiting
☐ Stomach Pains

HEMATOLOGICAL
☐ Bruise Easily
☐ Slow to Heal
☐ Anemia
☐ Past Transfusion

INTEGUMENTARY
☐ Rash or Itching
☐ Dry Skin
☐ Changes in Hair / Nails
☐ Color Changes
☐ Ulcers
☐ Lumps
☐ Sores

MUSCULOSKELETAL
☐ Muscle Pain or Cramps
☐ Joint Pain
☐ Stiffness / Swelling of Joints
☐ Back Pain
☐ Trouble Walking
☐ Gout

PSYCHIATRIC
☐ Anxiety
☐ Depression
☐ Confusion / Memory Loss

The information 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.

X _____ _____

Patient / Guardian Signature ***Date***

Bozeman Foot & Ankle Clinic, P.C.

Legal Name: (Last, First, M.I.) _____ Prev. Last Name: _____

Nickname: _____ Date of Birth: ____/____/____ SSN: _____ ☐ MALE ☐ FEMALE

Physical Address, City, State, Zip: _____

PO Box / Sec. Address, City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ May We Send Information Here? ☐ YES ☐ NO

Preferred Pharmacy: _____ City: _____ State: _____

Consent to Request Medication History From Your Pharmacy? ☐ YES ☐ NO

Your Employer: _____ Occupation: _____ Years There: _____
Employer's Address, City, State, Zip: _____
Work Phone: _____ May We Contact You at Work? ☐ YES ☐ NO

Name of Spouse/Partner: _____ Date of Birth ____/____/____
SSN: _____ Their Employer: _____
Employer's Address, City, State, Zip: _____
Employer's Telephone: _____ Years Employed There: _____

In Case of an Emergency, Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

1) **Preferred Language**: ☐ English ☐ Spanish ☐ Other _____
2) **Race:** ☐ White ☐ African American ☐ Asian/Pacific Islander ☐ Native American/Alaskan ☐ Latin American ☐ Decline to Specify ☐ Other _____
3) **Ethnicity:** ☐ Hispanic/ Latino ☐ NON Hispanic/ Latino ☐ Declined to Specify

A COPY OF YOUR INSURANCE CARD IS REQUIRED; PLEASE PRESENT THOSE CARDS TO THE RECEPTIONIST

Insurance Company: _____
Policy Number: _____ Group Number: _____
Subscribers Name: _____ DOB: ____/____/____ SSN: _____
Relationship to Patient: _____ Employer: _____

Do you have a secondary insurance? ☐ YES ☐ NO

Insurance Company: _____
Policy Number: _____ Group Number: _____
Subscribers Name: _____ DOB: ____/____/____ SSN: _____
Relationship to Patient: _____ Employer: _____

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE

Responsible Party: _____ Relationship to Patient: _____
DOB: ____/____/____ SSN: _____ Employer: _____
Employers Address, City, State, Zip: _____
Home Address, City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____
How Did You Hear About Our Practice? _____

Bozeman Foot and Ankle Clinic, P.C.

FINANCIAL POLICY

As a courtesy to you, we will file all insurance claims to your insurance carrier. A copy of your health insurance card is required; if we do not receive a copy of your card, we will not file your claim. It is your responsibility to ensure that the information we have on file is current and accurate information. Failure to provide us with the information that we need to process your claim will result in you being financially liable for the services provided.

We are participating providers with Medicare, Medicaid*, Blue Cross Blue Shield, Montana Health Co-Op, PacificSource and Allegiance. We also accept assignments for Tricare and Worker's Compensation. * If you have Medicaid, passport authorization is required for ALL visits.

It is our policy to collect copayments and/or deductible amounts at the time of service. If you do not know your copayment or deductible amounts, we will collect in payment in full. If you do not carry insurance or wish to file your claim yourself, payment in full is expected at the time of service. **Any balance over 45 days will be due from you.**

We will file Worker's Compensation claims as long as complete information is provided. It is the patient's responsibility to make sure all appropriate forms are coordination with the employer and the Worker's Compensation carrier.
Any balances over 45 days will be due from you.

If you require surgery, we do require a $300.00 presurgical deposit. We encourage our patients to contact their insurance company prior to surgery to verify eligibility, coverage, and preauthorization requirements.

Any returned checks will result in a NSF charge of $25.00.
We have a no show charge of $25.00 after 3 missed appointments with our office.

Radiographs taken in this office are the property of Bozeman Foot and Ankle Clinic, if you require copies, there is an additional charge.
We accept cash, check, Visa, Discover, American Express, and Mastercard payments. We also offer financing through CareCredit.

CONSENT

I hereby give my permission to Dr Wilshire or Dr Storm to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my or my child's/dependents condition.

AUTHORIZATION and RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance.

I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read, if I so chose, and understand the notice.

X _____ Date: _____

Signature of Patient, Responsible Party, or Parent, if the patient is a minor

Bozeman Foot and Ankle Clinic, P.C.

Verbal Communication Authorization Form

Patient Name: _____

Date of Birth: _____

By law, we cannot release any information regarding your care to anyone other than yourself without your expressed, written consent.

Please list any family members or others individuals, who may be involved in coordinating your care, or payment for care. Please indicate what types of information may be shared with each individual.

Name:	Relationship to Patient:	Type of Information:
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing

☐ Check here, if NO ONE is allowed to call about any of your information

Specific instructions or limitations:

_____

_____

We will rely on the information on this form when communicating regarding your care unless you request changes. Please notify our office if you wish to alter the above designations.

This authorization will be considered permanent unless revoked by you. To revoke this authorization, please send a signed, written request to: Bozeman Foot and Ankle Clinic, P.C. 931 Highland Blvd, Suite 3310, Bozeman, Montana 59715

Signature of Patient/ Legal Representative: _____

Date: _____ Relationship to Patient: _____

_____