



Bozeman Foot and Ankle Clinic, P.C.

Patient Name: _____ DOB: ___/___/___ SEX: MALE FEMALE

Height: _____ Shoe Size: _____ Weight: _____ Primary Physician: _____

Preferred Pharmacy: _____ City: _____

Employer: _____ Occupation: _____ Marital Status: _____

Current Medications: _____

Allergies & Reactions: _____

Surgical History (List any surgeries you have had and dates): _____

Medical History (Check Any Current or Past Medical Conditions)

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Degenerative Joint Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes, Type 1 or Type 2 |
| <input type="checkbox"/> DVT/PE | <input type="checkbox"/> GERD | <input type="checkbox"/> Gout | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> MSRA | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Frost Bite | <input type="checkbox"/> Other: _____ |

Have You Had, Currently Have Any of the Following Symptoms?

- | | | | | |
|-----------------------------------|------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tremors | <input type="checkbox"/> Involuntary Movements |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tingling | <input type="checkbox"/> Skin Color Changes |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Lumps | <input type="checkbox"/> Sores | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Muscle/ Joint Pain |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Backaches | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> OTHER: _____ |

Family Medical History: (If Any Family Members Had Any of the Above Conditions, Please List Below):

Tobacco Use: YES NO FORMER, Type: _____ Number of Years: _____ Packs/Day: _____

Alcohol Use: NONE RARELY WEEKLY DAILY, Drinks Per Day: _____, Drinks Per Week: _____

Activity Level: SEDENTARY MODERATE VIGOROUS

Reason for Today's Visit: _____

Location: RIGHT FOOT LEFT FOOT BOTH, Duration: _____ Pain on Scale of 1-10: _____

Aggravating Factors: _____

Treatments Tried: _____

Have You Had Any Tests Done? XRAYs CT SCAN MRI LABS, Where? : _____

Date of Injury: _____ Is this Work Related? : YES NO

Patient/ Legal Guardian Signature: _____ Date: _____



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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, 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, and MasterCard payments. We also offer financing through CareCredit.

CONSENT

I hereby give my permission to Dr Ebert, Dr Andrade, 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

