Bozeman Foot and Ankle Clinic, P.C.

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

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

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)

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

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

☐ Fainting	☐ Blackouts	☐ Numbness	☐ Tremors	☐ Involuntary Movements
☐ Weakness	☐ Paralysis	☐ Seizures	☐ Tingling	☐ Skin Color Changes
☐ Itching	☐ Lumps	☐Sores	☐ Stiffness	☐Muscle/ Joint Pain
☐ Gout	☐ Backaches	☐ Leg Cramps	☐ Varicose Veins	☐ 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***: _____

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, 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 Wilshire, 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

Bozeman Foot and Ankle Clinic, P.C.

Verbal Communication Authorization Form

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

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.

Signed original will be placed in your medical record.

To revoke this authorization, please send a 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: _____