

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? _____

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

When did the problem begin? _____

How was the problem onset? Sudden Gradual

The problem is: Improving Worsening Unchanged

The problem is worst: AM PM At Rest With Activity

What aggravates the problem? _____

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)

<i>Medication</i>	<i>Dosage</i>	<i>Medication</i>	<i>Dosage</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES & REACTIONS

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

Preferred Pharmacy: _____ City: _____

Primary Care Physician: _____

PAST MEDICAL HISTORY *If yes, check box. If no, leave blank.*

Diabetes Type 1 or 2 Duration: _____ Years, Last Blood Sugar _____ mg/dl HbA1c: _____%

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Excessive / Easy Bleeding | <input type="checkbox"/> Liver Disease (<input type="checkbox"/> Hepatitis) | <input type="checkbox"/> Rashes / Skin Condition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Leg Cramps / Leg Pain at Rest | <input type="checkbox"/> Raynaud's Disease / Phenomenon |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Foot / Leg Ulcer | <input type="checkbox"/> Lung Condition: _____ | <input type="checkbox"/> Seizure Disorder / Epilepsy |
| <input type="checkbox"/> Arthritis (<input type="checkbox"/> Osteo / <input type="checkbox"/> Rheum) | <input type="checkbox"/> Gout | <input type="checkbox"/> Mitral Valve Prolapse / Murmur | <input type="checkbox"/> Sickle Cell Disease / Trait |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Healing Problems / Keloids | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Apnea (<input type="checkbox"/> on CPAP?) |
| <input type="checkbox"/> Back Problems / Sciatica | <input type="checkbox"/> Heart Disease / Heart Attack | <input type="checkbox"/> Nervous Disorder / Depression | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Blood Clot / DVT | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low BP? | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Stroke <input type="checkbox"/> RT <input type="checkbox"/> LT (Year ___) |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteomyelitis / Bone Infection | <input type="checkbox"/> Thyroid Condition (<input type="checkbox"/> HI <input type="checkbox"/> LO) |
| <input type="checkbox"/> Cellulitis / Skin Infection <input type="checkbox"/> MRSA? | <input type="checkbox"/> Hormone Therapy | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Immune Disorder / HIV | <input type="checkbox"/> Previous Addiction to: _____ | <input type="checkbox"/> Women- are you pregnant or breast feeding? |
| <input type="checkbox"/> Dementia / Alzheimer's | <input type="checkbox"/> Kidney Disease (<input type="checkbox"/> Dialysis) | <input type="checkbox"/> Pulmonary Embolism | |

Continued on Back

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY (Circle Relative)

Mother Father Sister Brother GrandParent

- 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

CARDIOVASCULAR

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

EYES

- Vision Changes
- Cataracts
- Blurred or Double Vision
- Glaucoma
- Blindness

INTEGUMENTARY

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

NEUROLOGICAL

- Dizzy Spells / Fainting
- Numbness
- Tingling
- Seizures
- Weakness
- Paralysis / Tremors

EARS/NOSE/MOUTH/THROAT

- Hearing Loss
- Ringing in Ears
- Nose Bleeds
- Sore Throat / Voice Changes
- Sinus Problems
- Difficulty Swallowing

GASTROINTESTINAL

- Indigestion / Heartburn
- Diarrhea
- Nausea or Vomiting
- Stomach Pains

MUSCULOSKELETAL

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

RESPIRATORY

- Shortness of Breath
- Chronic / Frequent Cough
- Wheezing

ENDOCRINE

- Hormonal Problems
- Excessive Thirst
- Excessive Sweating
- Too Hot / Too Cold

HEMATOLOGICAL

- Bruise Easily
- Slow to Heal
- Anemia
- Past Transfusion

PSYCHIATRIC

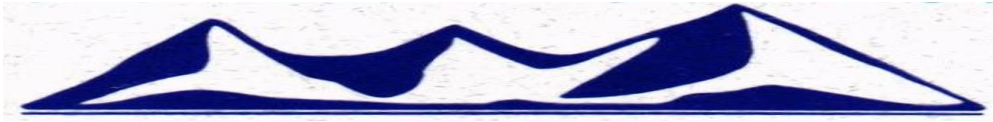
- Anxiety
- Depression
- Confusion / Memory Loss

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, and all major credit card payments. We also offer financing through CareCredit.

CONSENT

I hereby give my permission to 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

