THE FOOT CARE CENTER

BETTER FEET | BETTER HEALTH | BETTER LIFE

PATIENT INFORMATION

Name: _____ DOB: ____/_____/_____Gender: Male / Female

Street Address: _____City: _____ State: _____ Zip: _____

Mailing address (if different): _____S.S.#: _____

Spouse: _____ Spouse's DOB: ____/____/_____Spouses Phone: _____

EMPLOYER:

Employer: _____ Employer Phone: _____

Employer Address: _____Position: _____

EMERGENCY CONTACT:

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Race: o White o Asian o American Indian o African American
o Hispanic/Latino o Pacific Islander o Declined

Ethnicity: o Hispanic or Latino o Non-Hispanic or Latino o Patient Declined

Marital Status: o Married o Single o Divorced o Widowed

Employment Status: o Employed o Unemployed o Retired o Child o Student

RESPONSIBLE PARTY INFORMATION

Name: _____ Phone: _____

Address: _____City: _____State: _____Zip: _____

Responsible Party Employer: _____Employer Phone: _____

HOW DID YOU HEAR ABOUT US?

o Physician: _____ o Family/Friend_____

o Internet o Google o Facebook o Walked in o Yellow Book o Mailer o Former Patient

132 North Gould Street
Sheridan, WY 82801
Phone: 307-672-3457

3990 Avenue D
Billings, MT 59102
Phone: 406-252-5444

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NOTICE OF PRIVACY PRACTICES

I 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.

Signature of Patient/Responsible Party _____Date: _____

Printed Name of Patient/Responsible Party _____

I authorize information about my health be conveyed to me via:

Home Phone: _____ o Ok to Leave Detailed Message o Leave Message for Call-Back

Cell Phone: _____ o Ok to Leave Detailed Message o Leave Message for Call-Back

I authorize contact from this office to **confirm my appointments, treatment and billing** information via:

o Cell Phone Confirmation o Home Phone Confirmation o None of the following (opt out)

o Postal Mail o Email: _____ *we will never sell your email address!*

May we use your email for surveying purposes? o Yes o No

May we use it for advertising purposes? o Yes o No

AUTHORIZATION FOR RELEASE OF INFORMATION

Entity to Receive Information *Check each person that you approve to receive information and write out their name.*	**Information to be released**
o Spouse (provide name): _____	o Financial o Medical
o Parent (provide name): _____	o Financial o Medical
o Other (provide name): _____	o Financial o Medical

Form continues on back →

CONSENT TO SERVICES

The reason for requesting service at The Foot Care Center is that a medical condition requiring care exists. I, for myself or for this patient, consent to the medical care and treatment which The Foot Care Center considers to be necessary. The undersigned has read, understands, and accepts the Consent to Services.

Signature of Patient/Legal Guardian _____Date: _____
Printed Name of Patient/Legal Guardian _____

PATIENT FINANCIAL POLICY

- **Co-pays/co-insurance/deductibles/outstanding balances are due at the time of service.**
- By signing below, you agree to assign insurance benefits. In other words, you agree to have your insurance company pay the doctor directly. If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. **Therefore, all charges for your care and treatment are due at the time of service.**
- By signing below, you also authorize The Foot Care Center to release any medical and/or other information necessary to process your claim(s) in compliance with all HIPAA regulations. This is a lifetime authorization unless specifically revoked in writing by the undersigned.
- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- If a person **fails to show for an appointment** and doesn't provide 24 hour notice prior to cancelling then our health care proffesionals will charge the rate of $25.00 for payment of the no show appointment. These bills will not be billed to your insurance provider.
- According to the payment policy at the Center for Medicare Management, "CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate agaisnt Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for the service itself (to which the assignement and limiting charge provisions apply), but rather is a charge for a missed business opportunity." Therefore, our missed appointment policy applies equally to all patients (Medicare and non-Medicare).
- Financial Agreement: I agree as the person responsible for this account, to pay for all services and/or goods sold to me or my ward immediately upon demand by, The Foot Care Center. I further agree that in the event of non-payment to The Foot Care Center any amounts due under this agreement I will pay any reasonable attorney fees and courts costs that may be incurred. I agree that in the event this agreement is assigned to an outside collections.

Thank you for your cooperation in helping us provide the best care possible to you!

Signature of Patient/Responsible Party _____ Date: _____

Please sign both signature lines. Thank you!

THE FOOT CARE CENTER

Review of Systems

(check all that apply)

Patient: _____

Date: _____

Constitutional
- ☐Chills
- ☐Weakness
- ☐Fatigue
- ☐Fever
- ☐Weight Gain
- ☐Weight Loss
- ☐Dizziness
- ☐Fainting
- ☐Sweats

Nose
- ☐Discharge
- ☐Infection

Mouth
- ☐Bleeding
- ☐Dry Mouth
- ☐Dentures
- ☐Post Nasal Drip

Ears
- ☐Hearing Aids
- ☐Infections
- ☐Ringing

Throat/Neck
- ☐Lumps
- ☐Sore Throat
- ☐Tenderness
- ☐Hoarseness

Respiratory
- ☐Bronchitis
- ☐Cough
- ☐Pleurisy
- ☐Wheezing
- ☐Short of Breath

Cardiovascular
- ☐Chest pain
- ☐Hair loss on legs
- ☐Rheumatic Fever
- ☐Leg or Foot Ulcers
- ☐Vascular Grafts
- ☐Varicose Veins
- ☐Heart Murmur
- ☐Cramps in Legs/Feet
- ☐Palpations
- ☐Extremity(ies) Cool
- ☐Replacement Heart Valve

Gastrointestinal
- ☐Constipation
- ☐Excessive Thirst
- ☐Swallowing Problems
- ☐Diarrhea
- ☐Rectal Bleeding
- ☐Nausea

Psychiatric
- ☐Disorientation
- ☐Memory Loss

Skin
- ☐Dryness
- ☐Athlete's Foot
- ☐Keloid Scar
- ☐Itching
- ☐Hives
- ☐Fungal Nails
- ☐Mole Changes
- ☐Warts
- ☐Lumps
- ☐Ingrown Nails
- ☐Rash

Musculoskeletal
- ☐Lower Back Pain
- ☐Joint Stiffness
- ☐Restricted Motion
- ☐Arch Pain
- ☐Bunions
- ☐Corns
- ☐Hammer/Mallet Toes
- ☐In-toeing
- ☐Neuroma
- ☐Toe Walking
- ☐Joint Pain
- ☐Knee Pain
- ☐Muscle Cramps
- ☐Weakness
- ☐Broken Ankle
- ☐Calluses
- ☐Flat Feet
- ☐Heel Pain
- ☐Paralysis
- ☐Ankle Sprain
- ☐Broken Foot Bone
- ☐Childhood Foot Deformity
- ☐Gait (Walking) Problems
- ☐High Arch Feet
- ☐Muscle Stiffness
- ☐Shoe Insert Use

Neurological
- ☐Burning
- ☐Speech Disorders
- ☐Tremors
- ☐Fainting
- ☐Unsteady Gait
- ☐Neuromas
- ☐Numbness
- ☐Tingling
- ☐Black Outs

Endocrine
- ☐Goiter
- ☐Sweats
- ☐Thirst

Hematologic/Lymph
- ☐Easy Bruisability
- ☐Slow Healing Cuts
- ☐Bleeding easily
- ☐Swollen Glands
- ☐Chemotherapy
- ☐Blood Clots
- ☐Transfusion reaction

Genitourinary
- ☐Blood in urine
- ☐Flank Pain
- ☐Retention
- ☐Burning
- ☐Incontinence
- ☐Urgency
- ☐Excessive Urination
- ☐Infections
- ☐Kidney Stones

Male Genitalia
- ☐Hernias
- ☐Venereal Disease
- ☐Pain
- ☐Prostate Problems

Female Genitalia
- ☐Birth Control
- ☐Recent Pregnancy
- ☐Hernias
- ☐Venereal Disease
- ☐Menopause
- ☐Pain

Allergic/Immunologic
- ☐Hives
- ☐Runny Nose
- ☐Watery Eyes
- ☐Itchy Eyes
- ☐Sneezing
- ☐Itchy Nose
- ☐Stuffy Nose
- ☐Swelling

Eyes
- ☐Blurred Vision
- ☐Eyeglasses
- ☐Cataracts
- ☐Contacts
- ☐Infections

Medical History:

- ☐Anemia
- ☐Anxiety
- ☐Arthritis
- ☐Asthma
- ☐BPH
- ☐Liver Disease
- ☐Breast Cancer
- ☐CAD
- ☐CHF
- ☐COPD
- ☐Cancer
- ☐Cholesterol High
- ☐Dementia
- ☐Depression
- ☐Dermatitis
- ☐Diabetes
- ☐Epilepsy
- ☐GERD
- ☐Glaucoma
- ☐Gout
- ☐HIV
- ☐Headache
- ☐Hepatitis
- ☐Hypertension
- ☐MI
- ☐Migraine
- ☐Pneumonia
- ☐Renal Stone
- ☐Stroke
- ☐TB
- ☐Thyroid Disease
- ☐Ulcer (GI)

Form continues on back. →

☐ Not currently taking medication(s) ☐I give consent to pull my medication history from Surescripts
Pharmacy: _____

Current Medication(s):	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ No known drug allergies

Medication allergies:	Severity:	Reaction:	Onset Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Shoe Size: _____ Height: _____ Weight: _____
Primary Care Physician: _____ Date Last Seen: _____

Social History:
Yes/No Are you pregnant now? Number of childbirths/Ages? ____/_____
Do you drink alcohol? ☐ No History of Alcohol Use
Beer: ☐Social ☐Occasional ☐Light ☐Heavy
Wine: ☐Social ☐Occasional ☐Light ☐Heavy
Hard Liquor: ☐Social ☐Occasional ☐Light ☐Heavy

Do you use Tobacco? Never / Previously / Yes
If previously when did you quit? _____
If Yes Sources: Cigarettes / Cigars / Pipe / Chewing tobacco / Dipping Tobacco

☐No previous surgeries/hospitalizations

Surgeries/Hospitalizations (reason):	Year:
_____	_____
_____	_____
_____	_____

Family History:
List relationships to you of any family member who have had: (i.e. Father, Mother, Sibling, paternal/maternal Grandparent)

Diabetes	_____	Foot problems	_____
Arthritis	_____	Heart attack	_____
Stroke	_____	High blood pressure	_____
Cancer	_____	Birth defects	_____

Please fill out whole form. Thank you.