Welcome To Our Office

(PLEASE PRINT AND FILL OUT ALL ITEMS COMPLETELY)

This document will be shredded once the information is entered into the computer system.

Today's Date_____

Patient's Name_____ Date of Birth_____
How would you like our staff to address you/Nickname? _____ Male _____ Female _____

Social Security # _____-_____-_____

Home Address_____ City _____ State_____ Zip_____
Mailing Address _____ City _____ State_____ Zip _____
Home Phone # (__) _____ Email _____
(your e-mail address is needed to give you access to your medical records, confirm appointments or for other communication)

Preferred method of contact: Home phone__ Cell phone__ e-mail__

Race: (Circle) American Indian/Alaska Native Asian or Pacific Islander Black/African American Caucasian Japanese Chinese Filipino Hispanic or Latino Native Hawaiian or Other Pacific Islander Other/undertermined

Ethnicity: Non-Latino__ Latino__

Preferred Language: English__ Spanish __ Other__

Employer _____ Occupation/Section _____
Phone # (__) _____ Length of Employment_____(years) City/Town_____

Primary Care Physician _____ Date Last Seen _____

Emergency Contact _____ Relationship _____
Home Phone # (__) _____ Work Phone # (__) _____

If the patient is a minor, or living at home, the patient's parents or legal guardian needs to fill out this section.

Responsible Party _____ Relationship to patient ____Parent _____Legal Guardian
Social Security # _____ -_____ -_____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Home Phone # (__) _____

Employer _____ Occupation _____ Length of Employment_____(years)
Phone # (__)_____ City _____ State _____ Zip _____

How did you hear about our office? **(Please check appropriate source)**

My Doctor Referred Me _____ Insurance Company _____ Family Member _____(name)

I have seen Dr. Schultz before _____ Friend _____(name)

Our Sign __ Yellow Pages __ Our Website __ Google Search __ Yahoo Search __ Dex Online Search __ Radio Ad __
Coupon__ Style Magazine__ Speech Forum __ Reporter Herold __ Other_____
(please specify)

Insurance Information

Patient's Primary Insurance
Name of Company_____ Policy Holder's Name_____
Group # _____ Policy ID # _____

Patient's Secondary Insurance (If Applicable)
Name of Company_____ Policy Holder's Name_____
Group # _____ Policy ID # _____

Complete this section if someone else is the Primary Policy Holder

Responsible Party _____ Relationship to patient _____
Social Security # _____ -_____ -_____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Home Phone # (____) _____

Employer _____ Occupation _____ Length of Employment_____
Phone # (___)_____ City _____ State _____ Zip _____

Workers Compensation Claims
Referred By Doctor _____ Date of Accident _____
Employer (at time of accident) _____ Employer's Phone # (___)_____
Claim # _____ Name of Insurance carrier: _____
Adjuster's Name _____ Phone # (___)_____

Our office will file the insurance claims for medical and surgical charges. Self-Pay patients require payment on the date of service. Please remember, you are responsible for all fees, regardless of insurance coverage & all charges if a referral for HMO plans is not obtained prior to date of service.

I authorize the release of any medical information to process insurance claims.

I authorize payment directly to Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) for medical and/or surgical benefits, if any, otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

I have reviewed, understand and consent to the Financial Policies of Loveland Foot and Ankle Clinic, P.C. dba AFAC.

Signature of Patient or Legal Guardian _____ Date _____

LOVELAND FOOT AND ANKLE CLINIC P.C.

dba ADVANCED FOOT AND ANKLE CARE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Loveland Foot and Ankle Clinic, P.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Foot and Ankle Care reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Foot and Ankle Care at 1440 N. Boise Ave. Loveland, CO 80538.

With this consent, Advanced Foot and Ankle Care may call my home or alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, calls pertaining to my clinical care, including laboratory results, and billing issues among others.

With this consent, Advanced Foot and Ankle Care may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Advanced Foot and Ankle Care may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Advanced Foot and Ankle Care restrict how it uses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Foot and Ankle Care may decline to provide treatment to me.

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Advanced Foot and Ankle Care to use and/or disclose all medical protected health information (PHI) and billing information about me to or for the party or parties listed below, other than for information requested/required by your insurance company.

Name Relationship

_____

_____

When my information is used or disclosed following this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Advanced Foot and Ankle Care has acted in reliance upon this authorization. My written revocation, dated and signed, must be submitted to Advanced Foot and Ankle Care at 1440 N. Boise Ave. Loveland, CO 80538.

_____	_____	_____
Print Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian	Date

PATIENT MEDICAL HISTORY

Patient's Name: _____ Age: _____

Height: _____ Weight: _____

What condition(s) are you being seen for today? _____

_____

MEDICAL HISTORY: Have you had, or do you currently have any of the following? Please check **all** that apply.

___ Diabetes
___ Hepatitis/Liver problems
___Kidney Disease/Renal Failure
___ Hyperthyroid
___ Hypothyroid
___ Swollen glands
___ Gout
___ Rheumatic fever
___ Bone/joint disease
___ Rheumatoid Arthritis
___Osteoarthritis/DJD
___ Swelling of Joints
___ Back pain

___ Circulatory problems
___ High Blood Pressure
___ Low Blood Pressure
___ Heart Disease/ Heart attack
___Bleeding Tendency
___ Blood Transfusion
___ Stroke(CVA)
___ Swelling of feet or ankles
___ Slow to heal
___ Chest pain
___ Leg cramps
___Varicose veins
___ Anemia

___ Seizures
___ Paralysis
___ Neuritis/neuralgia
___ Neurologic Disorder
___ Numbness
___ Psychiatric history
___ Bipolar Disorder
___ Depression
___ Frequent anxiety
___COPD
___ Shortness of Breath
___ Asthma
___ Pneumonia
___ Excessive coughing

___Cancer _____
___ Currently pregnant
___ Large weight change
___ Weakness/fatigue
___ Stomach Ulcers
___ Digestive problems
___ Frequent sore throat
___ Frequent thirst
___Frequent headaches
___ Frequent urination
___ Skin rashes/conditions
___ Chicken Pox
___ Immune system problems
___ HIV/AIDS

Any other problems or conditions **not** listed above: _____

_____

HOSPITALIZATION AND SURGICAL HISTORY

List all previous surgeries or hospitalizations and dates:_____

_____

_____

Any problems healing? _____

List all previous significant **injuries** and dates (broken bones, sprains, ect)_____

_____

Other doctors you are currently seeing: _____

_____

Have you ever been advised to have a surgical operation which has not been done? _____

_____

Has anyone in your family had a similar foot problem? Who/What _____

_____

MEDICATIONS: Please list **ALL** medications you are currently taking

Medication	Strength (Dosage)	How Often Taken	Reason for Taking

ALLERGIES

___Aspirin	___ Penicillin	___ Sulfa	___Other antibiotics_____
___ Novacaine (Local Anesthetic)	___ Iodine	___ Codeine	___ Contrast dyes
___ Tape/ Band-Aids	___ Metals	___ Morphine	___ Environmental_____
___ Latex	___ Cortisone/Prednisone	___ Keflex	
___ Cipro	___ Food		

SOCIAL HISTORY (Please circle)

Marital Status: Single____ Married____ Widowed____

Employment: Employed-Part Time___ Full Time___ Not Employed___ Retired___ Student- Part Time___ Full Time___

Use of Alcohol: Never___ Occasionally___ Moderate___ Daily___ Quantity _____

Smoking: No___ Previously but quit _____ Yes, Packs per day? _____

Recreational/ Street Drug Use: _____ Never Rarely Daily

Exercise, Sports, or Recreational Activities_____

FAMILY HISTORY

Please list all diseases/conditions common to your family including heart disease, diabetes, rheumatoid diseases, arthritis, and genetic problems. (May refer to conditions listed under medical history on previous page)

If deceased, cause of death

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

I state that the above medical information is true and accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____

Signature of Patient/Parent or Guardian Date