Front Range Foot and Ankle Clinic

New Patient Information

Welcome to our practice. Thank you for considering Front Range Foot and Ankle Clinic for your healthcare needs.

Patient Information

Name: _____ Date: _____

SSN: _____ Date of Birth: _____ Height_____ Weight _____ Gender: M F

How Did You Hear About Our Practice? _____

Home Address: _____ City: _____ Zip: _____

Home Phone Number: _____ Cellular Phone Number: _____

Email Address: _____ Preferred contact method (Circle): Phone Email Text

Occupation: _____ Employer: _____

If Patient Is a Minor, Name of Responsible Party: _____ Relationship: _____

In Case of Emergency Notify: _____ Contact Number: _____

Relationship _____

Insurance Information

Primary Insurance Company: _____ Policy Holder's Employer: _____

Policy Number: _____ Group Number: _____

Primary Policy Holder Name: _____ SSN: _____

Policy Holder's Date of Birth _____

Secondary Insurance Company: _____ Policy Holder's Employer: _____

Policy Number: _____ Group Number: _____

Medical History

Briefly Describe the Reason for Your Visit Today: _____

Past Medical History:

Diabetes Type I	**Yes**	**No**	*Kidney Disease*	**Yes**	**No**
Type II	**Yes**	**No**	*On dialysis*	**Yes**	**No**
Heart Disease	**Yes**	**No**	*Skin Problems*	**Yes**	**No**
Type _____			*Gastric Ulcer*	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	*GERD (Acid Reflux)*	**Yes**	**No**
High Cholesterol	**Yes**	**No**	*Eye Problems*	**Yes**	**No**
Cancer	**Yes**	**No**	*Gastric Bleeding History*	**Yes**	**No**
*Type*_____			*HIV*	**Yes**	**No**
Asthma	**Yes**	**No**	*Depression*	**Yes**	**No**
Emphysema	**Yes**	**No**	*Anxiety*	**Yes**	**No**
Thyroid Disease	**Yes**	**No**	*Hepatitis*	**Yes**	**No**
Rheumatoid Arthritis	**Yes**	**No**	*Sickle Cell Disease*	**Yes**	**No**
Osteoarthritis	**Yes**	**No**	*Bleeding Disorder*	**Yes**	**No**
Gout	**Yes**	**No**	*Immunization status updated?*	**Yes**	**No**
Fibromyalgia	**Yes**	**No**	Other _____		

Past Surgical History:

Type of Surgery	Surgeon	Date

Medications: _____

_____

_____

Allergies:

Penicillin	**Yes**	**No**	*Tape/Adhesives*	**Yes** **No**
Sulfa	**Yes**	**No**	*Latex*	**Yes** **No**
Iodine/Shellfish	**Yes**	**No**	*Local Anesthetics*	**Yes** **No**

Other: _____

Prior Foot Problems:

Type of Condition	Treatment	Date

Primary Care Physician: _____ **Last seen:** _____

Social History:

Marital Status **M S W D** *Do you smoke?* **Y N**

Children **Y N** *If yes, how much?* _____

Alcohol Consumption: _____ *per day*

Athletic Activities: _____

Family History:

Health Condition	Relative

Office Policies

Payment Policy: I understand that I am responsible for all charges incurred by me for treatment regardless of insurance coverage and that payment of my account balance, as well as, co-pays are due at the time of service. We cannot bill insurance companies if we are not contracted with them. Our practice currently accepts cash and checks. A charge of $20.00 will be added to your account for all faulty or returned checks. In the event that your bill is turned over to a collection agency, you will be responsible for collection fees, attorney's fees, and court costs.

Cancellations: Individuals who fail to arrive at their designated appointments, without 24 hours of notice, will be assessed a $25 fee to compensate for the time that was allotted to them. Please provide as much advanced notice as possible when canceling your appointments. Canceling appointments causes inconvenience for the staff, doctor and other patients.

Medical Record Policy: Medical records are the property of Front Range Foot and Ankle Clinic. Our office will gladly release all requested information to the patient if requested in writing. There will be an office processing fee applied to cover the cost of materials and the personnel time involved in providing the medical record.

Privacy Policy: As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Front Range Foot and Ankle Clinic may not use or disclose your personal health information without your authorization. The practice has policies and procedures to comply with HIPPA law. Every attempt has been made to keep the process for patients and staff as efficient as possible. A complete form outlining the privacy practices of Front Range Foot and Ankle Clinic is on display within the waiting room and a personal copy is available upon request.

I have read and understand the policies listed above. I have also read and/or received a copy of the office privacy policy. I understand the policy, and have had any questions regarding this notice answered to my satisfaction. I certify that the information I have provided on this form is true. I authorize the release of any medical information necessary to process this insurance claim. I hereby authorize Dr. Mallett to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign the above named physician all benefits provided by my insurance company policy or policies for medical and surgical care.

Signature of Responsible Party: _____ **Date:** _____