Last Name:_____ First Name:_____ Middle Initial:____ BirthDate:_____Age:_____

Street:_____ City:_____ State:_____ Zip:_____ Contact # _____ Home/Cell

Marital Status (Circle One): Single Married Separated Divorced Widowed Sex: M F Email_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Employer:_____ Occupation:_____ Length at this job:_____

Employer Address:_____ City:_____ State:_____ Zip:_____ Work Ph:_____

Name of Spouse or Parent:_____ Birth Date:_____

Spouses Employer:_____ Work Ph:_____ Cell Ph.:_____

In case of emergency, contact

Name:_____ Relationship:_____ Home Ph:_____

Street:_____ City:_____ State:_____ Zip:_____ CellPh:_____

Insurance Information:

Who is responsible for payment of this account:_____ Relationship of this person to you:_____

Insurance

Name of Insured:_____ Name of Company:_____

Birth Date of Insured:_____ Address of Company:_____

Patient's SS#:_____ Group #:_____ Policy#:_____

Confidential Communications / HIPAA

I request that all written or oral communications to me (by telephone, mail or otherwise) by Rock Canyon Foot and Ankle Clinic and /or its staff be handled by using the above address and telephone number. I am responsible to notify the office of any change of above. I have been offered a copy of the Privacy Practice Notification of Rock Canyon Foot and Ankle Clinic and have read and understand the Notice.
May we leave a message? YES:_____ NO:_____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with_____ and assign directly to Rock Canyon Foot and Ankle Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all insurance submissions.

Responsible Party Signature:_____ Relationship:_____Date:_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Rock Canyon Foot and Ankle Clinic for any services furnished to me by that physician. I authorize any holder of medical information about me to release to Rock Canyon Foot and Ankle Clinic and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCJA1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:_____ Date:_____

Patient Health History

Name:_____ Age:_____ Height:_____ Weight:_____

Primary Doctor (first/last name_____ Last Visit:_____ Office Number:_____

Other Specialist / Doctors you see: _____

How did you hear about our office? Were you referred here by: Doctor:_____

Friend: _____ Internet Search:_____ Publication:_____

Allergies: Tape Metal/nickel Rubber/Latex Seasonal Foods: _____

Allergy to Medication:_____ Reaction:_____

List of Medications you are currently on:

Name of Medicine	Dose	Frequency	Reason for Taking	Who Prescribed It

Pharmacy that you use:_____ Pharmacy Phone #: _____

SURGERY – Indicate what type and year

_____

_____

_____

HOSPITALIZATION – (not for surgery) Indicate reason and year

_____

_____

_____

FOOT AND ANKLE HISTORY

Have you ever broken a bone in your foot or ankle? YES NO
Which bone?_____When?_____

Circle any of these that you have had:
Ankle Pain Foot Cramps Athlete's Foot Heel Pain

Have you had a problem with this area since that time? YES NO Bunions Ingrown Nails
What problem?_____ Corns Plantar Warts Calluses Swollen Feet What is your normal shoe size?_____ Flat Feet Tired Feet Have you ever been to a podiatrist before? YES NO
Why?_____ What problem brings you to the doctor today?_Injury? Work Comp?_____

Other General Important Health Questions:

Do you smoke? YES / NO Type (Circle any that apply) Cigarettes Cigars Other Amt. Per day:_____ Years smoked:_____
Do you drink alcohol? YES / NO Type (Circle any that apply) Hard Liquor Beer Wine Amt. Per day_____ Mth._____ Yr._____
For how many years?_____

Does any one of your blood relatives have or have had any of the following conditions? (please circle)

Diabetes Cancer Gout Heart Disease High Blood Pressure Tuberculosis

ARE THERE ANY OTHER MEDICAL CONDITIONS THE DOCTOR SHOULD BE AWARE OF?

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD:

EENT RESPIRATORY MENTAL HEALTH Nose Bleeds Asthma Depression Difficulty Swallowing Emphysema How Long_____ Difficulty Chewing Lung Disease Medication_____ Visual Problems Abnormal Chest X-Ray Anxiety Glaucoma Shortness of Breath Panic Attack Cataracts Use Oxygen at Home Agoraphobia Glasses Tuberculosis Obsessive/Compulsive disorder Contact Lenses Blood Clot in Lung Schizophrenia Hearing Problems Chronic Cough Chemical Dependency Sore in mouth that won't heal Blood in Sputum Substance_____ Thyroid Problem Other_____ Other_____

NEUROLOGICAL MUSCULOSKELETAL CANCER Numbness of Arms or Legs Rash Where?_____ Fainting Gout When?_____ Dizziness Arthritis Seizures/ Epilepsy Sore Not Healing OTHER DIAGNOSES Stroke Limited Motion in Joint OR CONDITION Headaches Back Problems Diabetic YES NO Migraine headaches Other_____ Year Diagnosed_____ Other_____

HEMATOLOGICAL GASTROINTESTINAL Have You Been Exposed Anemia Abdominal Pain to Any Infectious Diseases Bleeding Disorder Ulcer in Stomach in the Last Month? Hemophilia Hiatal Hernia Which:_____ Sickle Cell Anemia Nausea or Vomiting HIV Positive Constipation GENITOURINARY Other_____ Diarrhea Difficulty Urinating Change in Appetite Frequent Infections CARDIOVASCULAR Unexplained Weight Loss Kidney Problems Chest Pain / Angina Heart Burn Prostate Problems Heart Attack Gall Bladder Problems On Dialysis – Hemo / Peritoneal High Cholesterol Other_____ Abnormal Female Bleeding High Blood Pressure Other_____ Abnormal EKG LIVER Swelling of the Feet or Ankles Hepatitis Abnormal Heart Rhythm Yellow Skin / Jaundice Rapid Heart Rate Other_____ Artificial Heart Valve Pacemaker Blood Clot in Leg Other_____ I certify that the above information is true and current to the best of my knowledge. I give my permission to the Doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Signature:_____ Date:_____

PROTECTED HEALTH INFORMATION FORM Castle Rock Foot and Ankle Care wants to ensure your privacy. This form is intended to give you the opportunity to release medical information to designated parties (this does not apply to minors under the age of 18).

You may release pertinent medical information related to diagnosis and treatment from my office visits to the following parties:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Your
Name:_____Signature:_____Date:_____

PLEASE CIRCLE ALL THAT APPLY TO YOUR CONDITION:

What do your symptoms feel like? Aching Burning Cramping Dull Ill-defined Itching Pressure-like Pulling Sharp Shooting Sore Stabbing Tender Tearing Throbbing Tingling/Numbness

What makes the symptoms worse? Standing Walking Running Sitting Lying down Certain shoes
Other:_____

What makes the symptoms better? Nothing Rest Ice Heat Ibuprofen Changing shoes Periodic footcare
Other:_____

What prior treatment has been attempted? None Rest Ice Heat NSAIDs Physical therapy OTC Arch supports Changing shoes Periodic footcare Topical Rx OTC Topical Rx Custom Orthotics Prescription Rx

Do you have any Back Pain? Yes No Knee Pain? Yes- R L No Hip pain? Yes- R L No

How does your condition make you feel? (Please circle)

THIS SECTION IS FOR THE DOCTOR:

Vascular- _____/4 Right _____/4 Left Derm- Neuro- Tinel's: R L DTR: 0 1 2 3 4 S-W: _____/10 R _____/10 L Vibratory diminished: R L MSK- ROM Stability Strength Foot position: _____/10 R _____/10 L RCSP Ankle DF: Knee extended_____ Knee flexed_____ Limb length

Rock Canyon Foot and Ankle Clinic OFFICE POLICIES

COLLECTIONS POLICY In the event your account is assigned to a collection agency, you agree to pay a collection fee in the amount equal to 30% of the balance due assigned to the collection agency. There is a returned check fee of $50.00. If for any reason you write a check to our office that does not clear, This fee will be added to your account and collected at next visit.

DURABLE MEDICAL EQUIPMENT These items include, but are not limited to: Walking Boots, Night Splint, Ankle & Trilok Brace, Custom Orthotic & Children's Orthotic Inserts, Ped Pillows Inserts, Vionic footwear, Any accommodative over the counter items Items listed above are NON-RETURNABLE. We are restricted from re-selling items that have been taken from this office due to health regulation.

INSURANCE POLICY Please check with your insurance to find out if we are "in-network" with your policy and if you need a referral. Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. If proper authorizations or referrals are not obtained, this may reduce the benefits paid by your insurance company. This would be patient responsibility. Failure to inform us of any changes to insurance may result in denied claims, and responsibilities being 100% patients.

MEDICAL RECORDS/ X-RAYS Your records are the property of the office. The original copy must stay in the office. As a patient, you may request medical records and purchase copies per the State of Colorado fee schedule. We require a signed waiver and request 2 weeks' notice. We do not print or place your X-ray images on a CD. You must bring a USB drive into the office for X-rays.

NEW PATIENT, BOOTS, PROCEDURE & OA DEPOSITS Based on your deductible and amount met, we may take a deposit for the above-mentioned items. This deposit will be applied to your billed responsible amount. Remaining money will be re-issued via our billing department. If these services are non-covered by insurance they will be marked down as Self pay.

LATE/NO-SHOW POLICY If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. We strive to take time with each individual patient. Your punctuality affects your appointment, as well as others'. If you are 15 minutes late, we may be able to work you into the schedule at a later time or we may ask you to reschedule. Our office strives to stay punctual- this is because we do not overbook appointments in anticipation of cancellations. However, certain medical circumstances may be allowed exceptions. A no-show or short notice cancellation will result in a charge of $50.00. On the second no-show or late cancellation appointment, it will be up to the Doctor's discretion as to whether a discharge letter will be sent disengaging you from the practice. For CANCELED SURGERY, you will be charged $350.00 for cancelation. (If less than 7 days prior to scheduled surgery date.)

PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES:

I _____ have reviewed the above policies.

Signature_____Date_____