Foot & Ankle Care of Boulder

1400 28th Street, Suite 2
Boulder, CO 80303
Office: (303) 449-2000
Fax: (303) 449-9475
www.facboulder.net

PLEASE PRINT LEGIBLY IN BLACK INK, THANK YOU! Date:_____

Last Name:_____First(Legal):_____Middle Initial_____

Preferred Name:_____ Birth date: _____SS#_____Sex: M F Marital Status: M S W D O

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Race: ☐ African ☐ African American ☐ Asian ☐ Asian American ☐ Caucasian ☐ European American

Race Continued: ☐ Native American ☐ Native Alaskan ☐ Native Hawaiian ☐ Other Race:_____

Height:_____ Weight:_____Shoe Size:_____

Mailing Address:_____ _____
(City) (State) (Zip)

Home Phone: ( )_____ Cell/Pager #: ( )_____ Work Phone: ( )_____ext___

Please indicate which # you prefer we use to contact you: ☐ home ☐ cell ☐ work May we leave detailed voicemails? Y N

Email Address:_____ May we send appointment reminders to your email address? Y N

Family Doctor:_____ Phone #: ( )_____ Employer:_____Occupation:_____

Spouse:_____ Emergency Contact:_____ Relationship:_____Phone #: ( )_____

Primary Insurance Information:

Insurance:_____Policy Holder:_____ Relationship:_____ DOB_____

Policy Holder's Address:_____
(if different than above) (City) (State) (Zip)

Phone: ( )_____Employer:_____Subscriber#:_____Group# :_____

Secondary Insurance Information:

Insurance:_____ Policy Holder:_____Relationship:_____DOB_____

Policy Holder's Address:_____
(if different than above) (City) (State) (Zip)

Phone: ( )_____Employer:_____Subscriber#:_____Group#:_____

Person Responsible for Bill:

Name:_____Relationship:_____

Mailing Address:_____ Phone: ( )_____

(if different than above) (City) (State) (Zip)

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I hereby acknowledge and agree that if my account becomes delinquent it will be subject to collection service. I agree to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest on all such amounts outstanding. I understand and agree that my signature below confirms that I am authorizing Foot and Ankle Care of Boulder County and their billing service to call me on my mobile phone, if provided, for any reason to include collecting any balances due. I certify that the information provided is correct to the best of my knowledge. I authorize the release of any pertinent information regarding my medical care, and assignment of benefits from my insurance company to my Physician.

Signature: _____Date: _____

Parent or Guardian (if minor):_____Date:_____

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MEDICAL HISTORY

(Confidential Information-Important for Our Files and Your Health)

How did you hear about our practice? _____

What is the reason for your visit to our office? _____

What treatments have been done up to this point (including orthotics/arch supports)?

_____

What Pharmacy do you use? _____Pharmacy Phone#_____

Please list all medicines that you use ☐ None :

Start Date mm/dd/yyyy	Medication	Diagnosis for Medication	Strength	Frequency

Are you allergic to any MEDICATIONS? ☐ Yes ☐ No

Other allergies? Yes No What?_____

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Please list MEDICATIONS that you are ALLERGIC to and your REACTION:

_____

_____

_____

_____

What was the *location* of your allergic reaction? ☐ Skin ☐ Local ☐ Abdominal ☐ Systemic/Anaphylactic

What was the *severity* of your allergic reaction? ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe

If diabetic, *when* was your most recent Hgb A_1C lab?_____ *What* was the level?_____

FOR WOMEN ONLY: Are you pregnant? ☐ YES ☐ NO If yes, how many months _____

Indicate which of your immediate relatives have had any of the following diseases:

Cancer_____ Diabetes _____

Heart Trouble _____ High Blood Pressure _____

Kidney Disease _____ Mental/Emotional Illness _____

Stroke _____ Arthritis _____

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Please check "Yes" or "No" to indicate if you have had any of the following problems:

Yes	No	NATURE OF PROBLEM	COMMENTS AND GIVE APPROXIMATE DATE
		Recent Weight Loss	
		Headaches	
		Trouble with Hearing/Vision	
		Allergies/Hay Fever	
		Asthma	
		Thyroid	
		Diabetes	
		Skin	
		Anemia	
		Heart	
		Mitral Valve Prolapse/Heart Murmur	
		Chest Pain	
		High Blood Pressure	
		Circulation	
		Swelling in Feet or Ankles	
		Lungs (Pneumonia, TB, etc.)	
		Shortness of Breath (Cough, Pleurisy, Wheezing)	
		Liver Disease, Gall Bladder Disease or Jaundice	
		Stomach Trouble	
		Arthritis	
		Gout	
		Kidney Disease or Stones	
		Cancer	
		Bleeding Tendency	
		Scarring Tendency	
		Joint Pain or Stiffness	
		Numbness in Feet or Legs	
		Low Back Pain	
		Fainting or Convulsions	
		Psychiatric	
		Sleep Apnea- Do you use a CPAP? Have you had a sleep study? Results?	
		Do You Take Any Drugs? (Illegal or Legal) How Much?	

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Yes	No	NATURE OF PROBLEM	COMMENTS AND GIVE APPROXIMATE DATE
		Strokes	
		Pain in Other Areas	
		Other Illnesses or Problems	
		HIV Positive	
		Have you smoked cigarettes, cigars, a pipe or chewed tobacco in the past? How much?	
		Do you drink alcohol? How much?	
		Do you currently smoke cigarettes, cigars, a pipe, or chew tobacco? How much?	
		***Are your immunizations up to date?**	

Please give detail of any:

OPERATIONS	APPROX. DATE	PHYSICIAN	HOSPITAL

Have you had physical therapy? When? Where? For what condition? _____

_____

Is there anything you wish to tell the doctor privately? ☐ Yes ☐ No

Additional Information:_____

_____

Patient Signature:_____Date:_____

Witness:_____Date:_____

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Authorization to Disclose Information

I hereby acknowledge that I am aware of the ***Notice of Privacy Practices (HIPAA)*** for Foot and Ankle Care of Boulder County and that a copy is available for my records.

So that the physician(s) and/or office staff may address privacy issues, please indicate with whom we may discuss your routine and/or emergent care and treatment:

__Spouse (name) _____

__ Family member (name) _____

__Guardian (name) _____

__ Other (name) _____

__ Do not discuss my medical care and treatment with anyone other than healthcare providers and/or Representatives.

_____ _____
Name of patient (please print) Date of birth

Patient or Representative Signature: _____ **Date**: _____

Relationship of Representative_____

(HIPAA Notice, Revised 7/15/2013)