Cheyenne Foot & Ankle

Patient Registration and Health History

I Patient Information Date: _____

Patient _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____ Work _____

e-mail Address _____

Date of Birth _____ Age _____ Sex M or F

Patient SSN _____

Whom may we thank for referring you? _____

Single _____ Married _____ Divorced _____ Widowed _____ Spouse Name _____

II Basic Health Information

Primary Care Provider _____ Date Last Seen _____

Pharmacy Used _____ Location _____

*Primary Language Spoken _____

*Please select your race American Indian / Alaskan Native / Asian / African American
Caucasian / Pacific Islander / Other / Declined

*Please select you Ethnicity Hispanic / Non-Hispanic / Declined

* Requirement of our Government's Health Information Technology for Economic and Clinical Health Act (HITECH)

III Emergency Contact

Name _____ Relationship _____

Phone _____

IV Employment

Employed by _____

Business Address _____

Phone # _____

Occupation _____

Patient Name: _____

V Podiatric History (Are you currently or have you been treated in the past for any of the following conditions? Circle)

Ankle Pain Athlete's Foot Bunions Corns & Calluses Cramps or Numbness

Flat Feet Foot or Leg Cramps Heel Pain Ingrown Toenails Plantar Warts

What is the reason for your visit today? _____

_____

Have you been to a Podiatrist before? If yes, who _____ Last seen _____

How would you describe your pain? Sharp aching shooting burning dull other

Where exactly is your pain? (i.e. - between toes, great toe, bottom of heel, middle of arch, back of heel)

Which foot or ankle? Left Right

Pain level 0 1 2 3 4 5 6 7 8 9 10

none moderate severe

How long have you had this pain? # ____ days ____ weeks ____ months ____ years

Has the pain increased, decreased or stayed the same?

What appears to aggravate your pain?

What *have you tried* to help relieve the pain?

What *has helped* to relieve the pain?

VI Medical History

Please check if you have or have had any of the following:

___Heart trouble
___Kidney trouble
___High blood pressure
___Tuberculosis
___Stomach ulcers
___Broken bones in foot or leg
___Asthma-Emphysema
___Gout
___Have AIDS or are HIV positive
___Pancreatitis
___ Numbness in feet or legs
___ High Cholesterol

___Anemia
___Blood disease
___Circulation disease
___Hardening of arteries
___Reynaud's disease
___Varicose veins
___Arthritis
___Cancer
___Epilepsy
___Liver trouble
___Diabetes
___Thyroid problems

Are you allergic or sensitive to:

___Penicillin
___Erythromycin
___Sulfa
___Novocain
___Codeine
___Anesthetics
___Drugs
___Adhesive tape
___Foods
___Materials
___Other (please describe)

___None of above ___Other _____

Height _____ Weight _____ Shoe Size_____

Patient Name: _____

VII Surgeries & Hospitalizations (List all procedures, locations and any complications)

_____
_____
_____

VIII Medications (List all prescription medications that you are currently on. List dosage & frequency.)

_____
_____
_____
_____
_____
_____

X Social History

Smoking Status: ____Never ____Current Smoker ____Former Smoker ____Social Smoker

Smoking Amount: ½ pack/day 1 pack/day 2 pack/day 3 pack/day How long? _____

Do you drink alcohol? ___Yes ___No ___Rare ___Occasional ___Social ___Daily ___Former

Drinking amount: 1-2/day 3-4/day 5-6/day >7/day 1-2/week 3-4/week 5-6/week

Do you use recreational drugs? ___Yes ___No How often? _____

Do you exercise routinely? ___Yes ___No What activities? _____

XI Family History (Do you have any family members being treated for the following conditions? Who and what for?)

		Mother	Father	Sibling
Anemia	___Yes	_____	_____	_____
Arthritis	___Yes	_____	_____	_____
Asthma	___*Yes*	_____	_____	_____
Cancer	___Yes	_____	_____	_____
Diabetes	___Yes	_____	_____	_____
Heart Disease	___Yes	_____	_____	_____
High Cholesterol	___Yes	_____	_____	_____
Hypertension	___Yes	_____	_____	_____
Kidney Disease	___Yes	_____	_____	_____
Neurologic	___Yes	_____	_____	_____
Stroke/TIA	___Yes	_____	_____	_____
Thyroid Disease	___Yes	_____	_____	_____
Vascular Disease	___Yes	_____	_____	_____

Patient Name: _____

XII	Consent to Treat

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Colorado Prescription Drug Monitoring Program

IF YOU RECEIVE A PRESCRIPTION FOR "CONTROLLED" (SCHEDULE II THROUGH V) DRUG, YOUR IDENTIFYING PRESCRIPTION INFORMATION WILL BE ENTERED INTO COLORADO'S ELECTRONIC PRESCRIPTION DRUG MONITORING DATABASE (PDMP) WHEN THIS DRUG IS DISPENSED TO YOU. YOUR PRESCRIPTION INFORMATION IN THE DATABASE IS A PROTECTED HEALTH RECORD AND CANNOT BE ACCESSED BY NON-CAREGIVERS EXCEPT AS PART OF AN AUTHORIZED INVESTIGATION.

YOU HAVE A RIGHT TO ACCESS YOUR INFORMATION IN THE PDMP THROUGH THE COLORADO BOARD OF PHARMACY. YOU MAY SEEK CORRECTIONS TO THE INFORMATION AS YOU WOULD YOUR OTHER MEDICAL RECORDS.

I request the following restrictions to the use or disclosure of my health information:

____Accepted ____Denied

_____ _____

Patient/Parent or Guardian Signature Date

Patient Name: _____

FINANCIAL POLICY AND PATIENT AGREEMENT

1. If you are covered by an insurance plan which we maintain a contract, we will bill your insurance company for the services rendered. If your insurance has not paid us after 90 days, or you have not responded to your insurance on requested information, you will become responsible for payment in full. It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
2. At the **time of your visit** you will be responsible for payment of your co-pay, any outstanding patient balance and any dispensed supplies not covered by your insurance. Not all services provided in our office are a covered benefit under all insurance plans.
3. If your plan requires a referral and you do not have one, **You will be asked to pay for your visit in full or we will not be able to see you and your appointment will be rescheduled.** It is the sole responsibility of the patient to know your insurance plan and benefits, and to supply this office with a correct and current insurance card.
4. After your insurance has paid, please remember any remaining balance is due in full upon notice. Our office does not offer payment plans without prior arrangements with management. Any unpaid balances older than 60 days may be subject to account maintenance and finance charges of $35.00 per month. Returned checks will result in a $30.00 service charge and payment of all fees incurred resulting from the returned check. If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.
5. As a courtesy we do make confirmation calls. At times this may not be possible. It remains the responsibility of the patient to keep all scheduled appointments. Please notify us at least 24 hours in advance if you need to cancel or re-schedule your regular appointment (4 days for surgery). Here will be a $50 charge for regular appointments and a $250 charge for surgical appointments in the event you do not show up, cancel or change your appointment without 24 hours notice.
6. If X-rays are taken on your visit, they WILL NOT be released from our office as they become a permanent part of your patient chart. If you need them for another Doctor's appointment in the future, we charge a $25 fee, refundable when the films are returned.
7. We do not enter into disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider.
8. We do offer a quick pay discount to all cash patients who pay for their visits in full at the time of service. This is only available when your insurance is not billed and does not apply to custom orthotics.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Cheyenne Foot & Ankle, Inc./Dr. Jennifer Yull, DPM for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Patient/Responsible Party Signature: _____

Relationship to Patient: _____

Date: _____

Patient Name: _____

PHONE MESSAGE CONSENT

Your physician or other staff members may need to contact you. Please fill out the information below.

NAME: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

In an effort to protect your privacy, we have developed a policy regarding leaving medical information.

We will not leave messages with anyone except the patient or legal guardian
We will not leave any information on an answering machine
We will not leave any messages on a voice mail

UNLESS WE HAVE WRITTEN PERMISSION TO DO SO

Please read below and consider carefully whom you want to have access to your medical information.

I, _____ give Cheyenne Mountain Foot & Ankle permission to leave phone messages regarding my medical care at the following numbers. My medical care may be discussed with the person(s) listed below.

My cell voicemail _____Initial
My home answering machine _____Initial
My office/work voicemail _____Initial
Spouse (name) _____Initial
Other (names) _____Initial
_____Initial
_____Initial

Signature _____ Date _____

**** PLEASE INDICATE WHICH # IS BEST TO REACH YOU DURING OUR OFFICE HOURS ****

Patient Name: _____